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Elderly Abuse Statistics

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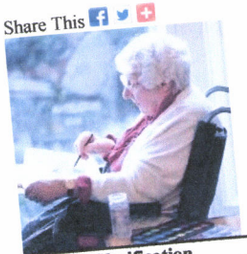

Statistic Verification	
Source: National Center on Elder Abuse, Bureau of Justice Statistics	
Research Date: 9.12.2012	
Elderly Abuse Statistics	**Data**
Number of elderly abuse cases in 2010	5,961,568
Percent of elderly population abused in 2010	9.5 %
Demographics of Elderly Abuse Victims	**Percent**
Percent of female elder abuse victims	67.3 %
Median age of elder abuse victims	77.9
Percent of white victims	66.4 %
Percent of black victims	18.7 %
Percent of hispanic victims	10.4 %
Breakdown of Reported Elder Abuse Cases	
Neglect	58.5 %
Physical Abuse	15.7 %
Financial Exploitation	12.3 %
Emotional Abuse	7.3 %
Sexual Abuse	0.04 %
All other types	5.1 %
Unknown	0.06 %
Family Perpetrated Elderly Abuse	
Percent of Adult Protective Service cases that involve elderly abuse	68 %
Percent of elderly abuse perpetrated by adult children or spouses	66 %
Percent of murder victims over 60 who were killed by their own offspring	42 %
Percent of murder victims over 60 who were killed by their spouses	24 %
Nursing Home Abuse	
Percent of nursing homes that lack adequate staff to properly care for patients	91 %
Percent of nursing homes that have been in violation of elderly abuse laws	36 %
Elderly defined as 60 years of age and older	

Tags:

statistics on elderly abuse ? prevalence of elderly abuse ? what is the main demographic of an elderly abuse victim ? what percent of the elderly population is abused each year ?

National Hospice & Palliative Care Organization

COMMENTARY AND RESOLUTION ON PHYSICIAN ASSISTED SUICIDE

Background

The years leading up to the end of the 20th century and the first years of the 21st century witnessed an unprecedented focus on end-of-life care. The combination of life-prolonging medical technologies and the rise of autonomy as the leading ethical principle in healthcare have moved the debate over ethical and legal aspects of intentionally hastening death into the forefront of theology, medical ethics, moral platforms, and public policy forums. Over this time period, ethical and legal views have shaped a professional consensus with regard to two key issues in end-of-life care, namely withholding and withdrawing life support in the face of terminal illness, including medical provision of (i.e., "artificial") hydration and nutrition.[1,2,3]

In two important cases[4,5] the Supreme Court ruled that there is not a constitutional right to aid in dying, and that states may (or may not) choose to criminalize physician involvement in a patient's willful hastening of his/her own death (commonly termed Physician Assisted Suicide [PAS].) Aggressive symptom control to relieve unnecessary pain and suffering, which is consistent with a patient's expressed wishes or values, is both legitimate and consistent with the ethical and legal practice of medicine, even if it may unintentionally hasten the patient's death. After these Supreme Court rulings, several states considered enacting laws to sanction PAS, but only Oregon, to date, has instituted such provisions as being lawful (State of Oregon Death with Dignity Act, 1997).

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[1] *In re* Quinlan, 355 A. 2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976)
[2] *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, (1990)
[3] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Deciding to Forgo Life-Sustaining Treatment. Washington, DC: Government Printing Office, 1973.
[4] *Washington v. Glucksberg*, 521 U.S. 702 (1997)
[5] *Vacco v. Quill*, 521 U.S. 793 (1997)

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Events have shown that end-of-life concerns extend beyond the logic of intellectual or even conceptual understanding. Belief systems, moral and religious views, political exigencies, and the emotions of loss and grief make it unlikely that biomedical ethics consensus statements or legal precedents will ever go unchallenged in this area. The longstanding tension between individual rights and external authority in our society comes fully to the fore with PAS. Realizing this, the Chief Justice of the Supreme Court concluded the *Glucksberg* case with the statement, "Throughout the nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[4, pp. 735-36]

Indeed, the debate has continued, with the benefit of exhaustive analyses and compelling arguments by proponents and opponents of PAS.[6,7] It is within this historical context, the ongoing considerations and formulations of public policy, and the evolution of palliative care services within U.S. healthcare that NHPCO undertook a review of the original National Hospice Organization (NHO) policy statement on PAS (dated 1996.)

NHPCO and the Policy-making Process

The NHPCO document titled *Resolution on Physician Assisted Suicide* (dated 2005) summarizes what was a lengthy, complex, and iterative decision-making process leading to its creation. The decision within the organization to review the original resolution and the significance of the topic as a matter of public policy warrants a comment about how this process proceeded within NHPCO.

The integrity of policy-making within NHPCO is dependent upon processes that respect both the membership and leadership roles and responsibilities of the organization. The governance structure assures a broad representational voice from its many constituents; the interdisciplinary senior leadership structure, guided by adherence to the organization's mission, vision, values and Board-approved strategic plan, assures a sound leadership organization perspective. The informing, independent, and then overlapping processes of literature review,

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[6] Foley K, Hendin H. The Case Against Assisted Suicide: For the Right to End-of-Life Care. The Johns Hopkins University Press, Baltimore MD, 2002

[7] Quill TE, Battin MP. Physician-Assisted Dying: The Case for Palliative Care & Patient Choice. The Johns Hopkins University Press, Baltimore MD, 2004

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Board of Director forums, Public Policy Committee and Ethics Committee input, Executive Committee and Senior Staff involvement and feedback throughout, assures a multilayered and in-depth synthesis of relevant stakeholder concerns and policy implications.

Patients and Family Needs at End of Life, NHPCO and Public Policy Decisions

Because NHPCO promotes excellence in care for all patients with life-limiting illnesses and their families, our policies must be crafted to consider what will serve their best interests. This includes an overriding necessity to maintain a strong, consistent, and persuasive voice for their needs, attainable only through wise stewardship of limited resources and ongoing building of good will among influential parties and stakeholders of all beliefs.

It is a difficult reality to accept, but any policy on a subject as rife with meaning--both concrete and symbolic--as PAS will necessarily fail to meet the needs of some individuals. Nevertheless, it is NHPCO's view that every person is the major stakeholder in her/his own end-of-life decisions and as such, it is the organization's intention that all voices and points of view should be respected, even if its policies cannot or do not coincide with every individual's personally-held views on end-of-life issues.

Foundational values of NHPCO include universal access to high quality palliative care, fully informed decision-making, mitigation of unwanted suffering, non-abandonment and support for the bereaved. All policies must strive to reflect or support the core tenets and mission of the organization while respecting the values of the larger society within which it operates. In discussions leading to a position statement on PAS, mindful of NHPCO's mission and the needs of the vast majority of terminally ill patients and their families, two dominant assertions emerged:

> **NHPCO Values Life**: The philosophical constructs and evolving practices of hospice/palliative care are concerned foremost with the dignity of persons throughout the trajectory of life-limiting illness. When symptoms or circumstances become intolerable to a patient, effective therapies are now available to assure relief from almost all forms of distress during the terminal phase of an illness without purposefully hastening death as the means to that end. These modalities and the means to safely administer them must be within the expertise of and available from all hospice/palliative care providers as an alternative to PAS.

RESOLUTION AND COMMENTARY ON PHYSICIAN ASSISTED SUICIDE

WHEREAS, The National Hospice and Palliative Care Organization is the leadership voice for the nation's hospice and palliative care communities; and,

WHEREAS, The National Hospice and Palliative Care Organization's membership comprises individuals and organizations with perspectives and expertise drawn from direct experience with those facing a terminal illness, making them uniquely and highly qualified to provide comment to the Congress, the Administration, the Courts, the media and the general public; and,

WHEREAS, The National Hospice and Palliative Care Organization supports an American's right to have knowledge of and access to all forms of therapy that have been shown to enhance quality of life and reduce suffering; and,

WHEREAS, The National Hospice and Palliative Care Organization supports the right of all persons to participate in all decisions regarding their care, treatment, and services; and,

WHEREAS, Avoiding a prolonged period of suffering as one dies is a goal commonly expressed by seriously ill persons; and,

WHEREAS, The goal of hospice and palliative care is to facilitate safe and comfortable dying with focus on quality of life as each dying person defines it;

WHEREAS, The National Hospice and Palliative Care Organization does not support the abandonment of the person and remains committed to meeting the medical, emotional, psychological and spiritual needs of people and their families; and,

WHEREAS, There has been ongoing public attention to physician assisted suicide; therefore, be it

RESOLVED, That the National Hospice and Palliative Care Organization reaffirms its commitment to the value of life and to the optimization of the quality of life for all people at the end of life.

RESOLVED, That the National Hospice and Palliative Care Organization supports improved knowledge of and access to hospice and palliative care for terminally ill people and their families, regardless of individuals' views, decisions, or preferences regarding physician assisted suicide.

RESOLVED, That the National Hospice and Palliative Care Organization does not support the legalization of physician assisted suicide.

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To Be Effective as "The Architect and Catalyst for Social Change in End-of-Life Care" NHPCO's Efforts Must Focus on Improving Access to High Quality End-of-Life Care: Our society's ability to meet the comprehensive needs of patients with life-limiting illnesses and their family members (from day-to-day caregiving through bereavement) are severely deficient. The work that must be done in the areas of professional education, public awareness, healthcare systems development, alignment of financial driving forces, public policy revision to eliminate barriers and promote best practices, and research to increase the fund of knowledge needed to improve care, is monumental.

Conclusion

Through the review process concerning a policy statement on PAS, NHPCO's commitment to improving access to high quality end-of-life care is reaffirmed and this will remain the thrust of its public policy efforts. These considerations lead to the resolution that the National Hospice and Palliative Care Organization does not support the legalization of physician assisted suicide. NHPCO looks forward to participating in and guiding the ongoing dialogue and debate to continuously improve upon and promote comfort and dignity in life closure, and affords the highest regard for patient choice and self-determination[8].

(Resolution continued on next page.)

[8] Approved by NHPCO Board of Directors, September 2005

fundamental right legal definition

noun

A basic or foundational right, derived from natural law; a right deemed by the Supreme Court to receive the highest level of Constitutional protection against government interference.

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Assisted suicide: Conspiracy and control

(http://connect.oregonlive.com/user/rattig/index.html) By **Rick Attig, The Oregonian**
(http://connect.oregonlive.com/user/rattig/posts.html)
on September 24, 2008 at 7:01 PM, updated September 24, 2008 at 7:10 PM
Print (http://blog.oregonlive.com/opinion_impact/print.html?entry=/2008/09/assisted_suicide_conspiracy_an.html)

We applaud **The Oregonian's recommendation (http://www.oregonlive.com/opinion/index.ssf/2008/09/washington_states_as** Washington voters reject I-1000, the physician-assisted suicide measure.

We must comment on two realities: first, the group controlling assisted suicide in Oregon is also the group controlling what the public is told; second, the claim that Oregon is a leader in improved end-of-life care because of assisted suicide is inaccurate.

The editorial board correctly notes "a coterie of insiders run the program, with a handful of doctors and others deciding what the public may know".

The group promoting assisted suicide, so-called "Compassion and Choices (C&C)", are like the fox in the proverbial chicken coop; in this case the fox is reporting its version to the farmer regarding what is happening in the coop. Members of C&C authored and proclaim they are the stewards of Oregon's assisted suicide law. They call it "their law". They have arranged and participated in 3/4ths of Oregon's assisted suicide cases. Their medical director reported she'd participated in more than 100 doctor-assisted suicides as of March 2005. A physician board-member reported in 2006 that he'd been involved with over forty such patients. Their executive director reported in September 2007 that he has attended more than 36 assisted suicide deaths. He has been involved in preparing the lethal solution. Yet, he is not a doctor.

In 2006, C&C's attorneys intimidated the Oregon Department of Human Services (DHS) to change to euphemisms in referring to Oregon's assisted suicide law. The limited DHS reports of assisted suicides is another indication of this organization's influence. Information that is damaging to the "good public image" of Oregon's assisted suicide law is hidden or glossed-over in the DHS reports. As such, we believe the initials "C&C" of this organization more properly reflect its repeated public behavior ---that is, "Conspiracy & Control".

Regardless of one's perspective on assisted suicide, all citizens should be concerned about the controlling influence of this death-promoting organization. In all other areas of medicine, we are striving for increased transparency---not conspiracy and control.

What about assisted suicide causing improved end-of-life care?

There is improved end-of-life care in Oregon. In training physicians, we have sought to improve patient-physician communication, and improve patient care at many levels. We have made improvements. However, similar improvements have occurred in other states that have not legalized assisted suicide. Many states do better than Oregon in this area. The latest data ranks Oregon 9th (not 1st) in Medicare-age hospice-utilization; 4 of the top 5 states have criminalized assisted-suicide. The Wisconsin Pain Policies

Studies Group issues grades regarding states' pain-policies. While Oregon & Washington both have high grades on their pain-policies, an OHSU study documented that after 4 years of assisted suicide in Oregon there was a decline in end-of-life pain-control. This doesn't prove that the pain-control decline was due to assisted suicide. At the same time, the data doesn't support the claim that legalization of assisted suicide improved care at the end-of-life.

In summary, we should all be wary of the false "C&C" claims.

Kenneth R. Stevens, Jr., M.D., is Vice-president, Physicians for Compassionate Care Education Foundation.

William L. Toffler, M.D., is National Director, Physicians for Compassionate Care Education Foundation.

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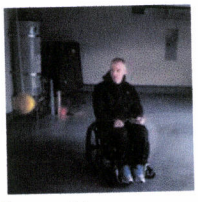

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Man Charged in Kidnapping Attempt of His Mother

November 24, 2011, Great Falls Tribune

A Great Falls man was charged Thursday with elder abuse, forgery, trespass to property and the attempted kidnapping of his 81-year-old mother.

According to police, Mark Aafedt admitted to police that he had written 40 to 50 checks from his mother's bank account without her permission. He also admitted he was aware of his mother's diminishing mental capacity and lack of ability to manage her own financial accounts.

Concerns about Aafedt's mother were expressed to police previously by Mark Aafedt's brother, Joe Aafedt. Joe reported to the police suspicions of his brother's activities after noticing a box of his mother's rings had gone missing and checks that had been written for $5,402, police said.

The elderly woman is a resident at Eagles Manor, where, after a reported dispute between the brothers, Mark Aafedt was told by police to stay away from the property.

On Nov. 21, Joe Aafedt spoke with Detective Bruce McDermott about concerns for his mother's safety, fearing that his brother would attempt to kill or kidnap their mother for financial gain, according to the police.

Two days later, Joe Aafedt called police to inform them that Mark Aafedt was at the Eagles Manor trying to take their mother. Eagle Manor staff had told Mark Aafedt he was not supposed to be there or remove his mother from the property but he insisted that he would return her in 45 minutes and was just going out for ice cream, police said.

Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

By News sources

POSTED: 11:35 PM PDT September 7, 2011
UPDATED: 4:36 AM PDT July 14, 2011

BEND, Ore. - Former Bend real estate broker Tami Sawyer was arraigned Thursday on state charges of criminal mistreatment and aggravated theft, four days after her arrest at Portland International Airport.

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Sawyer was taken into custody by Port of Portland police after arriving on a flight back from Mexico, where she was allowed to go and check on rental property.

She appeared before Deschutes County Circuit Judge Wells Ashby, who continued her bond at $50,000 but set no travel restrictions, prosecutors said.

Ashby said she can travel outside of Oregon but has to sign and submit a waiver of extradition, should that be needed.

Sawyer faces charges of first-degree criminal mistreatment and aggravated theft., accused of selling Thomas Middleton's home and pocketing the proceeds.

The judge set her next court appearance for Sept. 6 at 8:30 a.m., when she is scheduled to enter a plea.

Sawyer and husband Kevin are scheduled for trial in December on federal fraud and money-laundering charges.

Former Bend real estate broker Tami Sawyer was arrested Sunday night at Portland International Airport on a Deschutes County warrant issued late last week after her indictment on felony charges of criminal mistreatment and aggravated theft.

Sawyer, 48, was booked into the Multnomah County Jail around 9 p.m. Sunday, about a half-hour after her arrest, reportedly having just flown back to Oregon after a judge agreed to let her go check on rental property that she and husband Kevin own in Cabo San Lucas, Mexico.

Deschutes County Circuit Judge Alta Brady signed an arrest warrant with $50,000 bail last Thursday, two days after she was indicted on a first-degree criminal mistreatment charge that alleges she took custody of Thomas Middleton, ?a dependent or elderly person,? for the purpose of fraud.

The first-degree aggravated theft charge alleges that in October 2008, Sawyer stole more than $50,000 from the Thomas Middleton Revocable Trust.

State and court documents show Middleton, who suffered from Lou Gehrig?s disease, moved into Sawyer?s home in July 2008, months after naming her trustee of his estate, The Bulletin reported Saturday. Middleton deeded his home to the trust and directed her to make it a rental until the real estate market improved.

Instead, Sawyer signed documents that month to list the property for sale, two days after Middleton died by physician-assisted suicide. The property sold in October of that year for more than $200,000, the documents show, and it was deposited into an account for one of Sawyer?s businesses, Starboard LLC, and $90,000 of that was transfered to two other Sawyer companies, Genesis Futures and Tami Sawyer PC.

Sawyer and her husband, a former Bend police captain, face trial scheduled for December in Eugene on federal charges of money laundering, wire fraud and conspiracy to commit wire fraud. They are accused of using investor money to pay for personal property, causing investors to lose $4.4 million.

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A federal judge twice gave permission for her to travel to Mexico, once in May and again last month.

First-degree aggravated theft is a Class B felony, punishable by up to 10 years in prison. First-degree criminal mistreatment is a Class C felony, punishable by up to five years in prison.

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Developer Has History Of Shady Dealings (http://greensburgdailynews.com/local/x212455948/Developer-Has-History-Of-Shady-Dealings)

Sheila G. Miller
(http://greensburgdailynews.com)

Editor's Note: This is the Oregon half of a two-part story written in conjunction with the Bend Bullettin in Bend, Ore. The Daily News worked with the paper in Bend in order to uncover the FBI investigation into the Sawyers and the real estate deals they were involved in locally and in Oregon.

With dozens of properties in Deschutes County, Ore., and farther afield, Kevin and Tami Sawyer have busily expanded their real estate empire over the past decade.

And when things seemed to slow in Central Oregon, the Sawyers set their sights on a new location: a small town in Indiana.

While the FBI has not revealed anything about its investigation into the Sawyers and their companies, one of those companies comes up time and again in lawsuits, Deschutes County property records and an unfinished project in Indiana: Starboard LLC.

It is this company that has at least one lawyer wondering whether it violated securities laws by taking money from investors, and investors wondering where the money they gave Starboard has gone.

Over time, the couple has been involved in 10 companies, has taken out millions of dollars in loans from more than a dozen banks, and had ended up owning nearly 50 properties around Deschutes County.

About 10 days ago, Bend Police Chief Sandi Baxter announced Kevin Sawyer would retire from his position as captain, overseeing investigations and support services; he'd been on paid administrative leave since February, when the FBI investigation became public. The Sawyers would not comment for this story. The couple and their companies are the subject of a half-dozen lawsuits.

Starboard is named in four of those civil suits.

Starboard was registered by Tami Sawyer with Oregon in 2004, and she is the only member listed on

the company's registration. Another company, named Starboard Indiana, was registered in Oregon by lawyer Philip Anderson in June 2007, then was transferred to Indiana in July 2007. In August 2008, that company dissolved in Oregon, but it remains active in Indiana.

Beginning in 2004, Starboard began buying up properties, some in default, then quickly turning profits on them. All told, in Deschutes County, Starboard bought more than 20 properties between 2004 and 2008, spending a total of nearly $5 million on them. Most were sold or traded.

Starboard maintains control of 18 lots, all in the South Briar development in southeast Bend, Ore.

That land remains undeveloped.

As Starboard's local activity slowed in 2007, its work in another part of the country was just getting going.

The company has taken an interest in Greensburg, Ind., according to court and county clerk documents. In a lawsuit filed by Bend resident Parris Menoni, Menoni alleges she is owed $136,668.23. That money, she alleges, was for an investment into Starboard. A document included in the court record details Starboard's investments into local properties, as well as in Indiana and Mexico.

"Currently, Starboard LLC has a project that we are working on in Greensburg, Indiana, the home of the new Honda Automotive Assembly Plant," the document states. "Greensburg has a strong rental market and virtually no homes for sale and is facing a large influx of families relocating for the newly created jobs. Foreseeing a great potential for profit, Starboard has purchased a 22-acre parcel adjacent to the Honda plant."

The document goes on to detail Starboard's plan to develop 200 row houses with rooftop patios, as well as an adjacent 10-acre property with a bank, strip mall, restaurants, gas station and quick mart.

Indeed, in August 2007, Starboard bought a 22-acre plot in Greensburg for $10 "and other valuable consideration." The lot was purchased from Greensburg LLC, a company based in Bend and run by Richard Bilyeu, according to Oregon Secretary of State and Decatur County, Ind., property records. Bilyeu refused to comment for this story.

Decatur County records show Greensburg LLC took the property over from Rolling Meadows LLC, a now-dissolved Oregon company also registered to Bilyeu in Bend. Rolling Meadows paid $556,000 for the property when it was purchased in August 2006 from Greensburg couple Larry and Cynthia McCamment.

In August 2007, Greensburg LLC also provided a short-term loan to Starboard for $750,000, to be repaid a month later.

According to a Decatur County mortgage release filed in February 2008, that loan was repaid. First, though, records show Greensburg LLC filed a lawsuit against Starboard in October, and in January 2008 the case was

closed.

Menoni's promissory note, signed by Tami Sawyer, is dated Jan. 1, 2008. Just 24 days after Menoni allegedly gave more than $130,000 to Starboard to help develop that 22-acre piece of land, Decatur County documents

show Starboard sold the land to Synergyz LLC for $1 "and other valuable consideration." Synergyz, a company registered in Delaware and Indiana, uses the same Bluff Drive address as several other Sawyer companies. Synergyz then took out a $1 million mortgage on the property, signed by Tami Sawyer. The mortgage was marked as a construction loan, but the property remains a large swath of grass.

The Sawyers have a stake in another property in Greensburg as well. In March 2008, Starboard Indiana purchased the Greensburg Mobile Home Park for $444,000. It was to pay an initial $125,000 and then make monthly payments of $2,524. Tami Sawyer also signed that paperwork.

Menoni is not the only person suing Starboard. The company, and the Sawyers, are also being sued by Ondi and Michael Hibbs; David Redwine and his wife, Laurie Turner-Redwine; and a company called Redstone Development. The Redwines and the Hibbses allege in their lawsuits that they made a series of loans to Starboard and the Sawyers, and those loans were never repaid.

While Menoni's lawsuit indicates she believed she was investing in Starboard, that might not be the case at all. According to Bill Hansen, the chief investigator with the Oregon Division of Finance and Corporate Security, neither Tami nor Kevin Sawyer, nor any of their companies, are registered with his office to

sell securities or seek investments. None of the Sawyers' companies is registered with the Securities and Exchange Commission, a federal agency that regulates the investment industry.

"We see a lot of companies try to get around registering with us," Hansen said. "But if people are giving a company money with the expectation of a return, if their money is handled out of their control, that's securities."

Securities are traditionally either debt or equity; debt securities can include things like bonds or bank notes, while equity securities are shares or stock in a company.

Steve Bender, a professor at the University of Oregon School of Law, said some investors, usually very wealthy people, are exempt from securities laws because they are expected to be "money-intelligent."

Even then, though, Bender said, the company would likely have to be registered at the state level. Transferring property from one company to another for small amounts could be problematic, Bender said.

"That would be a breach of fiduciary duties owed to the shareholders," he said. "You couldn't just basically gift a property without fair value because that would be a breach of the duty of those owners. They owe fiduciary duty of loyalty and care, and to sell it at an unreasonably low amount, that is often the basis for a lawsuit.

"You would owe a duty to those investors to get fair value."

But, Bender said, because Tami Sawyer appears as Starboard's only member in its Oregon registration, and Synergyz has no members listed in its Delaware or Indiana registrations, those who allege to have invested in Starboard have fewer rights.

"If they're just unsecured lenders and they weren't accorded the status of an owner in a corporation, it would be different," Bender said. "It would depend on how those deals were structured. They may

have thought they were gaining ownership interest, but if they were just creditors, there are still some cases you could say you owe a duty to your creditors to not loot the corporate assets."

Attorney Claud Ingram, who represents Menoni and another client in Montana who Ingram said lost money investing in Starboard, thinks the pair ought to have been protected.

"Legally, they gave (Menoni) a document in which they indicated she was investing in a company, but instead of giving her a membership or a stock certificate, they gave her a note," Ingram said. "But in Oregon, a promissory note, where given for an investment purpose, is a security by definition of Oregon statute. She is legally under the law an investor."

Ingram said he believes there are at least 15 Starboard investors, although he said that's a conservative estimate. And he said they're not all here in Oregon.

But Ingram said he doesn't think Menoni has much chance of getting back the funds she allegedly invested.

"It'll be a long, drawn-out process," he said. "There's been lots of transactions and transfers of property."

While Menoni and others wait for their days in court, the Sawyers have other problems to worry about. In addition to the six lawsuits against them in Deschutes County Circuit Court, five of their properties are in default. And they've failed to pay property taxes in Deschutes County on several of their properties, this year and last.

In total, the couple owes $15,878.70 on 22 properties, including all their lots in South Briar, a development in southeast Bend, and their own home on Scottsdale Drive. According to the Greensburg Daily News, Indiana records indicate Starboard Indiana and Synergyz also failed to pay property taxes in 2008, and currently has $900 outstanding for the mobile home park and $71.40 for the undeveloped 22 acres.

"It would appear that these people ran short of money and started borrowing to pay their expenses," Ingram said. "And they kept right on going after the economy had gone to hell in a handbasket."

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medicalserialkillers.kaiserpapers.org

Date: Thu, 23 Sep 1993 12:09:29
From: ICAD Editors
Subject: FWD>Caregivers who Kill

---------- Subject: Caregivers who Kill Nurses, physicians, and attendants have a long history of killing people with disabilities, young children, and the elderly. Jane Toppan who confessed to killing 31 and is believed by some experts to have killed 70 to 100 people as a student nurse, and nurse's aide around the turn of the century is quoted as saying, "That is my ambition, to have killed more peopleQmore helpless peopleQthan any man or woman who has ever lived."

Jane's ambition, however, was never realized since many others seem to have substantially exceeded her numbers. For example Donald Harvey, a nursing assistant, also known as the Angel of Death, killed people in at least 3 US hospital over a period of 17 years and is belived to have killed twice as many as Toppan.

In many other cases, patterns of suspicious deaths in institutional care occur involving 50 to well over 100 probable homocides with no one convicted of the murders. Motives for these murders seem unclear. When cornered many of the perpetrators claim that these are mercy killings, but this rarely seems to fit with the facts. For example, the husband of Cathy Wood a nursing assistant convicted of killing five people in a Grand Rapids Michigan, Nursing Home, suggested that she should receive a light sentence because these were mercy killings and the people killed had little to lose, but Cathy suggested that the motive was merely "fun," and that she and her accomplice chose people by their initials. Trying to spesll out an anagram "MURDER" with their initials in a book that recorded deaths in the nursing home. Similarly Beverly Allit, a nurse recently convicted in England of killing 5 children and thought to be responsible for the deaths of 60 or more, killed some who had only minor illnesses (e.g., a bad cold). This is hard to explain as euthanasia.

Hospitals, nursing homes, and institutions often seem to be more concerned about their reputations than apprehending the perpetrators. For example, in another turn of the century case, Jeanne Webber, had already been indicted for murdering 8 children as a babysitter, when she was hired as a nursing assistant in a children's hospital. When she was caught in the act of strangleing a child in her first week of work, the hospital administration quietly dismissed her to avoid embarassment. Shortly thereafter she returned to childcare and child murder.

Caregiver serial killers probably may be responsible for more deaths each year than the transient sexual psychopath serial killers that receive much more public attention.

Nevertheless, there has been little serious work profiling this group of murderers.

The University of Alberta Abuse & Disability project is currently initiating a project to study this group. We would be interested in hearing about any other cases that you may know of.

So far we have identfied about 40 cases. Also, we would be interested in any ideas that you may have about motivation, patterns, or other aspects of these offenses.

One of the questions that these murders raise is related to other forms of "euthanasia" and withholding care. Are these another (more respectable form) of the same urge to kill or are these efforts better intentioned? Any thoughts would be greatly appreciated.

Charles Cullen: Healthcare Serial Killer

BY *Katherine Ramsland*

Healthcare Serial Killers: Ramifications


Dr. Gregory Moffatt

Dr. Gregory Moffatt, a therapist and expert in risk assessment, discusses the more general phenomenon, in *Blind-Sided*, of murders that occur where they are not expected. That is, many murders are committed by people who seem nonviolent. Moffatt argues that there are certain predictors of a predisposition toward violence that are generally overlooked by people acquainted with the killer. There is a way to identify the person who may become violent, and he offers a list of warnings to take seriously. While he does not directly address the population of nurses and physicians who may become killers, his warning signs are nevertheless applicable.

Among the signals for potential violence are:

A past history of violence

- Threats
- Social isolation
- Substance abuse
- Job instability
- Poor self-image
- Anger/depression
- Poverty
- Severe situational stress
- Feelings of being wronged
- Weak support system

Cullen fit a number of these, although his social isolation made it difficult for people around him to know what he might have been going through. It should have been clear that he had issues with anger and depression, and that he had little money and few (if any) friends. But he was a quiet, reclusive man who did not let others know him. Nevertheless, some coworkers *did* suspect him, and they were correct.

Among those warning signs that Moffatt does not include that are more specific to healthcare serial killers are the fact that Cullen would often predict who was going to die, he was often seen coming from rooms where patients soon died, and he jumped from one institution to another, often being fired or leaving under suspicion.

People acquainted with someone with the potential to kill, says Moffatt, should:

- Take threats or statements of intent seriously
- Seek assistance or resist violence when it occurs
- Have a plan in place before violence occurs
- Call for help immediately
- Don't panic

Front Page

Serial Killers

Most Notorious
Sexual Predators
Truly Weird & Shocking
Unsolved Cases
Partners in Crime
Killers from History
All Serial Killers

Gangsters

Terrorists & Spies

Notorious Murders

Criminal Mind

Photos

With Cullen, some of the patients were certain that he had done something to them that ought not to have happened, such as giving them an injection. Had they demanded to know what he was doing, or been more assertive about reporting him, the chances are better that he'd have been caught and more thoroughly investigated.

Perhaps the wake-up call from this case and the new legislation will deter some potential angels of death of killing. It remains to be seen. We know that more HCSKs have been convicted in the past fifteen years than in decades before, so it's clear that we're either catching more of them or more of them are developing. In either case, hospitals must acknowledge their existence and train their personnel to spot them, document their movements, and take action. All of us who will become patients depend on this.

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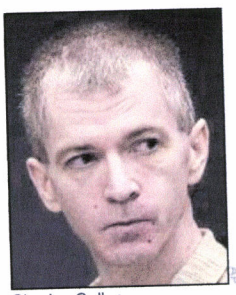
» *Slideshow: Last Words from Death Row*
» *Slideshow: Top Ten Bestiality Cases of 2011*
» *Slideshow: Last Meals Before Execution*
» *Most Famous Murder Houses Photo Gallery*
» *Slideshow: Most Compelling Crime Photos*
» *Mugshots from Rock Bottom: Women*
» *Slideshow: Pretty But Deadly*
» *Stories About Serial Killers and Related Investigations from the Crime Library on truTV.com*

Charles Cullen: Healthcare Serial Killer

BY *Katherine Ramsland*

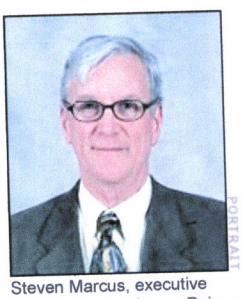
Warnings



Charles Cullen

On the nights prior to both patients suddenly going into critical conditions, a 43-year-old male nurse named Charles Cullen had ordered digoxin. Yet he'd requested it for patients under his own care, not for either of the victims. And he'd canceled the orders. There was no evidence with which to confront him, although the drug was clearly missing, and the administration had no indication that Cullen, a nurse with 16 years of experience, had ever been negligent or sloppy... or worse. They looked through other records in their search for answers.

No one was fired or laid off pending the investigation results. Yet other patients suffered from having high levels of drugs in their systems, and Steven Marcus, a toxicologist and executive director of New Jersey Poison Information and Education System, warned SMC that July that they had a poisoner on their staff. He had spotted a cluster of at least four cases. Hospital officials resisted his analysis, reports the *Star-Ledger*, and had even complained about Marcus to the state's health department, saying he had rushed to judgment and was pressuring them unduly. Yet he insisted that someone had to go to the police and get a forensic investigation underway.



Steven Marcus, executive director of New Jersey Poison Information and Education System

Administrators were not trying to save face so much as hoping to prevent the facility from erupting into chaos. They continued to look into the situation internally. Still, they couldn't ignore the obvious: Cullen was the common factor in these four cases, each with either a high level of insulin or digoxin, and one more of whom had died. He'd even accessed Reverend Gall's records after his death. Had he been checking something? Yet Cullen continued to work.

Then two more patients suffered similar overdoses and on October 31, after 13 months on the job, Cullen was fired. Somerset County Prosecutor Wayne Forrest had initiated his own investigation, starting with Cullen's work history. He found the man to have worked at an alarming number of healthcare organizations, including four in New Jersey, and from some he'd been fired. Forrest could only hope they weren't faced with a serial killer.

Rick Hepp, a reporter from the Newark *Star-Ledger* did some quick sleuthing and went to Cullen's bungalow-style home in Bethlehem, PA, and knocked on the door. Cullen answered. A seemingly quiet man, thin and pale, he had sadness in his dark eyes and looked weary. Hepp told Cullen that someone at the Center was being investigated. Cullen admitted that he was the nurse in question.

"They've been asking a lot of questions about me at Somerset Medical Center," he stated. But he wouldn't say why he'd been fired.

Hepp discovered that, despite the investigation, Cullen was still licensed and technically able to find

Family Crusade Brings Exhumation in Case of Suspect Nurse

By RICHARD PÉREZ-PEÑA
Published: January 22, 2004

This article was reported by Richard Pérez-Peña, David Kocieniewski and Jason George and was written by Mr. Pérez-Peña.

For the first time since a nurse confessed last month to killing dozens of patients, investigators today plan to exhume the body of a possible victim, a woman whose family accused the nurse of murdering her more than a decade ago.

Members of Helen C. Dean's family say the nurse, Charles Cullen, gave her an unauthorized injection while she was a patient at Warren Hospital in Phillipsburg, N.J. The next day, Sept. 1, 1993, Mrs. Dean, who was in good condition at age 91 after surgery for breast cancer, died suddenly of heart failure.

The exhumation, scheduled to occur this morning at Fairmount Cemetery in Phillipsburg, takes place as seven counties in New Jersey and Pennsylvania, where Mr. Cullen worked at nine hospitals and a nursing home, are grappling with whether to order more bodies exhumed, and which ones. Though Mr. Cullen has admitted to killing 30 to 40 people during his career, he has not provided details and prosecutors and the police say that so far they have solid reason for suspicion in only a few cases. They say many deaths pose a quandary: investigators lack the evidence to justify digging up corpses, but exhumation may be the only way to get that evidence.

"We'll have to take it on a case-by-case basis," said John Morganelli, the district attorney of Northampton County, Pa., who said exhumations there remain a possibility.

Wayne J. Forrest, the prosecutor in Somerset County, N.J., had one body exhumed in October, that of the Rev. Florian J. Gall, the Roman Catholic priest Mr. Cullen is charged with killing last summer, but he would not say whether he expects to seek more exhumations.

The handful of similar cases around the country have run into the same trouble. In 1998, Efren Saldivar, a respiratory therapist at a California hospital, told investigators that he had killed 40 to 50 patients over many years, but not which ones. Detectives looked into deaths during just a fraction of his career and found well over 100 they considered possibly suspicious. Unable to narrow the list, they chose 20 to exhume - more or less at random, they said - and found that 6 had been poisoned.

Proving that Mr. Cullen killed Mrs. Dean became an obsession for her son, Larry A. Dean, a history professor at Harrisburg Area Community College, who died of cancer in 2001. He pestered the Warren County prosecutor and the county medical examiner, who investigated the case a decade ago but turned up no physical evidence. His cousin, Sharon

Jones, recalled that Mr. Dean collected boxes of documents, saved tissue samples from his mother's autopsy in his freezer, and attempted to trace the career of Mr. Cullen as he bounced from hospital to hospital.

In 1993, an autopsy was conducted on Mrs. Dean's body, and tissue and blood samples were sent to two laboratories for tests. The laboratories checked for about 100 different drugs, but not for digoxin, the common heart medication that investigators now think was Mr. Cullen's favorite weapon.

Mr. Cullen was charged last month with killing Father Gall and attempting to kill Jin Kyung Han, a 40-year-old Basking Ridge homemaker, with large, unauthorized doses of digoxin. Ms. Han recovered but died of cancer three months later.

Dr. Isidore Mihalakis, the Warren County medical examiner, said that in the case of Mrs. Dean, "of course we'll test for digoxin, and as long as we're at it, we're going to run a complete drug screen." He said it is uncertain, at best, what kind of evidence would remain after a decade.

Mrs. Jones, Helen Dean's niece, said she and Larry Dean urged investigators back in 1993 to test for digoxin, after hearing about its effects on a television program - a contention that Dr. Mihalakis and Frank Bucsi, the acting county prosecutor, have said they could neither confirm nor refute. "There might be a little disappointment if they don't find anything, but the real disappointment is that they didn't do the proper investigative work 10 years ago," Mrs. Jones said.

Today's exhumation actually involves disturbing two sets of remains. Sharon Jones said her cousin Larry was cremated, and said the urn containing his remains was buried in his mother's grave, atop her casket.

Dr. Mihalakis was the medical examiner in 1993, but he said he was away when Mrs. Dean died, and said another doctor conducted the autopsy and ordered the tests. Asked why digoxin was not included in that screening, he said, "Quite frankly, I don't know."

Larry Dean told family members and investigators that he visited his mother in Warren Hospital on Aug. 30, 1993, the day before she was to be discharged. A male nurse entered the room and asked him to leave. When the nurse left and Mr. Dean re-entered, his mother said, "He stuck me," showed him a needle puncture wound on her thigh, and said that she was not scheduled for any medications.

He said that he and Mrs. Dean had complained to her doctor and others at the hospital and when the nurse returned to the room, she pointed him out and he was identified as Charles Cullen. The hospital administration has declined to comment on the case.

Dr. Mihalakis said the original autopsy turned up a puncture wound and that medical records showed that Mrs. Dean was not due for any medications.

The next day, Mrs. Dean was discharged, but she turned ashen and died a few hours later, about 20 hours after the mysterious injection. Experts say that a dose of digoxin can be lethal many hours after it is given, and even more than a day later.

For the counties involved, the Cullen case has become a significant drain on resources, requiring them to comb through dozens or hundreds of patient records, some of them a decade old or more. Mr. Forrest, the Somerset County prosecutor, said his office had 7 or 8 of its 50 detectives working on the case, along with several others. Mr. Cullen's last job, in 2002 and 2003, was at Somerset Medical Center, and he told investigators he had killed 12 to 15 people there.

Mr. Forrest said the task for his county was made easier because the hospital's records were fully computerized, no paper records had been destroyed as they often are after several years, and people's memories are still relatively fresh. "So we aren't experiencing

some of the difficulties that some others are," he said.

The Northampton County Council has given the coroner, Zachary Lysek, permission to add two full-time assistants to his staff of 15 part-time medical examiners, mostly because of the Cullen case, but the county has not yet figured out how to pay for them. Joseph Devine, chief investigator in the Morris County prosecutor's office, said the county had one investigator and one lawyer working full-time on the case, and was considering hiring a doctor and a nurse to help comb through Morristown Memorial Hospital records - all of this for a hospital where no firm suspicions have yet been raised.

Woman convicted of killing patients with bleach awaits fate

By the CNN Wire Staff
updated 10:48 AM EDT, Mon April 2, 2012

CNN.com

(CNN) -- A woman who was found guilty of killing five patients at a Texas dialysis center by injecting them with bleach will learn her fate this week.

A jury in Angelia County found Kimberly Saenz, 38, guilty last week of capital murder in connection with the deaths.

On Monday, they will consider whether she should be sentenced to death or put in prison for life.

The deaths took place in April 2008 when Saenz was an employee at DaVita Dialysis Clinic in Lufkin, about 120 miles north of Houston.

Prosecutors said she killed five patients by injecting them with bleach. Five others survived.

Two witnesses said they saw Saenz use a syringe to draw bleach from a cleaning pail and inject it into the IV lines of patients.

And prosecutors said internet search queries on her laptop showed Saenz had looked up bleach poisoning and whether it could be detected in dialysis lines.

Saenz did not take the stand at the month-long trial. Her attorneys argued she was being used as a scapegoat by the clinic to explain the unusually high number of deaths that April, according to CNN affiliate KTRE-TV in Lukfin.

Medics were called to the clinic at least 19 times that month.

The spate of deaths forced DaVita to close its doors until it met state requirements.

State of California ≈ Department of Justice
OFFICE of the ATTORNEY GENERAL
KAMALA D. HARRIS

Attorney General Kamala D. Harris Announces Sentencing of Kern Valley Health District Hospital Administrator

Wednesday, August 29, 2012
Contact: (415) 703-5837

BAKERSFIELD -- Attorney General Kamala D. Harris today announced the sentencing of the former hospital administrator of Kern Valley Health District, a rare case in which a hospital administrator is being held criminally responsible for conduct by a lower-ranked employee.

Pamela Ott, former hospital administrator of the Kern Valley Health District, pled no contest to one felony count of conspiracy to commit an act injurious to the public health based on her failure to adequately supervise the Director of Nursing. During Ott's tenure as administrator, Director of Nursing Gwen Hughes administered psychotropic medications to 23 elderly residents in order to chemically restrain them for staff convenience. Three patients died.

"Ott neglected her responsibility to monitor the practices of her employees and, in doing so, she endangered the health and well-being of vulnerable residents," Attorney General Harris said. "California has strong laws to prevent elder abuse and we will enforce them so we can protect the most vulnerable among us."

Ott was sentenced to three years formal probation, 300 hours of volunteer service, restitution pending conclusion of civil lawsuits. She is required to comply with all orders from the Registered Nursing Board, which is conducting its own investigation into the matter.

In July 2012, Dr. Hoshang Pormir, the Medical Director, was also sentenced to 300 hours of volunteer service, restitution pending conclusion of civil lawsuits, and a requirement to comply with all orders from the Medical Board. Pormir failed to conduct examinations of patients or monitor their reactions to medications.

In January 2007, the Department of Public Health began an investigation into complaints stemming from the Healthcare District and found that 23 residents suffered adverse reactions as a result of chemical restraints and unnecessary medications. The Department of Justice's Bureau of Medical Fraud and Elder Abuse took over the case after the Department of Public Health completed its report.

Ott received complaints, some as early as September 2006, concerning Hughes' conduct towards staff. Several staff members also had previously informed Ott that residents were forcefully restrained and injected with medications. Ott disregarded the complaints and directed staff to comply with Hughes' instructions.

Hughes will face a jury trial beginning October 29, 2012 in Kern County Superior Court. She is being charged with multiple felony counts of elder abuse resulting in death, elder abuse resulting in great bodily injury, and assault with force likely to cause great bodily injury.

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Dr. Harold Fredreck Shipman

Dr Harold Fredrick Shipman was born Janurary 14th 1946 – 13 January 2004 and was an English doctor and one of the most prolific serial killers in history. With 250+ murders being positively ascribed to him.
On 31 January 2000, a jury found Shipman guilty of 15 murders. He was sentenced to life imprison.
After his trial, the Shipman Inquiry, chaired by Dame Janet Smith, investigated all deaths certified by Shipman. About 80% of his victims were women. The youngest victim was a 41-year-old man. Much of Britain's legal structure regarding health care and medicine was reviewed and modified as a direct result of Shipman's crimes. Shipman is the only British doctor who has been found guilty of murdering his patients.

Early years

Harold Frederick Shipman was born in Nottingham, England, the second of four children of Vera and Harold Shipman, a lorry driver. His working class parents were devout Methodists. Shipman was particularly close to his mother, who died of cancer when he was 17. Her death came in a manner similar to what later became Shipman's own modus operandi: in the later stages of her disease, she had morphine administered at home by a doctor. Shipman witnessed his mother's pain subside in light of her terminal condition, up until her death on 21 June 1963.
Shipman received a scholarship to medical school, and graduated from Leeds School of Medicine in 1970. He started work at Pontefract General Infirmary in Pontefract, West Riding of Yorkshire, and in 1974, took his first position as a general practitioner (GP) at the Abraham Ormerod Medical Centre in Todmorden, West Yorkshire. In 1975 he was caught forging prescriptions of pethidine for his own use. He was fined £600, and briefly attended a drug rehabilitation clinic in York. After a brief period as medical officer for Hatfield College, Durham, and temporary work for the National Coal Board, he became a GP at the Donneybrook Medical Centre in Hyde, Greater Manchester, in 1977.
Shipman continued working as a GP in Hyde throughout the 1980s and founded his own surgery on Market Street in 1993, becoming a respected member of the community. In 1983, he was interviewed on the Granada television documentary World in Action on how the mentally ill should be treated in the community.

Detection

In March 1998, Dr Linda Reynolds of the Brooke Surgery in Hyde, prompted by Deborah Massey from Frank Massey and Son's funeral parlour, expressed concerns to John Pollard, the coroner for the South Manchester District, about the high death rate among Shipman's patients. In particular, she was concerned about the large number of cremation forms for elderly women that he had needed countersigned. The matter was brought to the attention of the police, who were unable to find sufficient evidence to bring charges; The Shipman Inquiry later blamed the police for assigning inexperienced officers to the case. Between 17 April 1998, when the police abandoned the investigation, and Shipman's eventual arrest, he killed three more people. His last victim was
Kathleen Grundy, a former Lady Mayor of Hyde, who was found dead at her home on 24 June 1998. Shipman was the last person to see her alive, and later signed her death certificate, recording "old age" as cause of death.
Grundy's daughter, lawyer Angela Woodruff, became concerned when solicitor Brian Burgess informed her that a will had been made, apparently by her mother. There were doubts about its authenticity. The will excluded her and her children, but left £386,000 to Shipman. Burgess told Woodruff to report it, and went to the police, who began an investigation. Grundy's body was exhumed, and when examined found to contain traces of diamorphine (heroin), often used for pain control in terminal cancer patients. Shipman was arrested on 7 September 1998, and was found to own a typewriter of the type used to make the forged will.
The police then investigated other deaths Shipman had certified, and created a list of 15 specimen cases to investigate. They discovered a pattern of his administering lethal overdoses of diamorphine, signing patients' death certificates, and then forging medical records indicating they had been in poor health.
Prescription For Murder, a book by journalists Brian Whittle and Jean Ritchie, reports two theories on why Shipman forged the will. One is that he wanted to be caught because his life was out of control; the other reason, that he planned to retire at age 55 and then leave the United Kingdom.

Trial and imprisonment

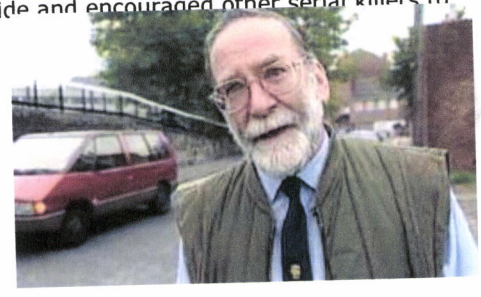
Shipman's trial, presided over by Mr Justice Forbes, began on 5 October 1999. Shipman was charged with the murders of Marie West, Irene Turner, Lizzie Adams, Jean Lilley, Ivy Lomas, Muriel Grimshaw, Marie Quinn, Kathleen Wagstaff, Bianka Pomfret, Norah Nuttall, Pamela Hillier, Maureen Ward, Winifred Mellor, Joan Melia and Kathleen Grundy, all of whom had died between 1995 and 1998.

On 31 January 2000, after six days of deliberation, the jury found Shipman guilty of killing 15 patients by lethal injections of diamorphine, and forging the will of Kathleen Grundy. The trial judge sentenced him to 15 consecutive life sentences and recommended that he never be released. Shipman also received four years for forging the will. Two years later, Home Secretary David Blunkett
confirmed the judge's whole life tariff, just months before British government ministers lost their power to set minimum terms for prisoners.
On 11 February 2000, ten days after his conviction, the General Medical Council formally struck Shipman off its register.
Shipman consistently denied his guilt, disputing the scientific evidence against him. He never made any statements about his actions. His defence tried, but failed, to have the count of murder of Mrs Grundy, where a clear motive was alleged, tried separately from the others, where no obvious motive was apparent. His wife, Primrose, apparently was in denial about his crimes as well.
Although many other cases could have been brought to court, the authorities concluded it would be hard to have a fair trial, in view of the enormous publicity surrounding the original trial. Also, given the sentences from the first trial, a further trial was unnecessary. The Shipman Inquiry concluded

responsible for about 250 deaths. The Shipman Inquiry also suggested that he liked to use drugs recreationally.
Shipman was probably
Despite the prosecutions of Dr John Bodkin Adams in 1957, Dr Leonard Arthur in 1981, and Dr Thomas Lodwig in 1990 (amongst others), Shipman is the only doctor in British legal history to be found guilty of killing patients. According to historian Pamela Cullen, Adams had also been a serial killer—potentially killing up to 165 of his patients between 1946 and 1956—and it is estimated he may have killed over 450, but as he "was found not guilty, there was no impetus to examine the flaws in the system until the Shipman case. Had these issues been addressed earlier, it might have been more difficult for Shipman to commit his crimes." H. G. Kinnell, writing in the British Medical Journal, also speculates that Adams "possibly provided the role model for Shipman"

Death

Harold Shipman committed suicide by hanging in his cell at Wakefield Prison at 06:20 on 13 January 2004, on the eve of his 58th birthday, and was pronounced dead at 08:10. A Prison Service statement indicated that Shipman had hanged himself from the window bars of his cell using bed sheets. Some British tabloids expressed joy at his suicide and encouraged other serial killers to follow his example; The Sun ran a celebratory front page headline, "Ship Ship hooray!"
Some of the victims' families said they felt cheated, as his suicide meant they would never have the satisfaction of Shipman's confession, and answers as to why he committed his crimes. The Home Secretary David Blunkett noted that celebration was tempting, saying: "You wake up and you receive a call telling you Shipman has topped himself and you think, is it too early to open a bottle? And then you discover that everybody's very upset that he's done it."
Despite The Sun's celebration of Shipman's suicide, his death divided national newspapers, with the Daily Mirror branding him a "cold coward" and condemning the Prison Service for allowing his suicide to happen. The Independent, on the other hand, called for the inquiry into Shipman's suicide to look more widely at the state of Britain's prisons as well as the welfare of inmates. In The Guardian, an article by Sir David Ramsbotham (former Chief Inspector of Prisons) suggested that whole life sentencing be replaced



by indefinite sentencing as these would at least give prisoners the hope of eventual release and reduce the risk of their committing suicide as well as making their management easier for prison officials.
Shipman's motive for suicide was never established, although he had reportedly told his probation officer that he was considering suicide so that his widow could receive a National Health Service (NHS) pension and lump sum, even though he had been stripped of his own pension. His wife received a full NHS pension, which she would not have been entitled to if he had died after the age of 60. FBI profiler John Douglas asserted that serial killers are usually obsessed with manipulation and control, and killing themselves in police custody, or committing "suicide by cop", can be a final act of control. Shipman had been encouraged to take part in courses which would have had him confess his guilt. After refusing, he became emotional and close to tears when privileges - including the opportunity to telephone his wife - were removed. Privileges had been returned the week before the suicide. Additionally, Primrose, who had consistently believed that Shipman was innocent, might have begun to suspect his guilt. According to Shipman's ex-cellmate Tony Fleming, Primrose recently wrote her husband a letter, exhorting him to "tell me everything, no matter what".

Aftermath

In January 2001, Chris Gregg, a senior West Yorkshire detective was selected to lead an investigation into 22 of the West Yorkshire deaths. Following this, a report into Shipman's activities submitted in July 2002 concluded that he had killed at least 215 of his patients between 1975 and 1998, during which time he practiced in Todmorden, West Yorkshire (1974–1975) and Hyde, Greater Manchester (1977–1998). Dame Janet Smith, the judge who submitted the report, admitted that many more suspicious deaths could not be definitively ascribed to him. Most of his victims were elderly women in good health.
In her sixth and final report, issued on 24 January 2005, Smith reported that she believed that Shipman had killed three patients, and she had serious suspicions about four further deaths, including that of a four-year-old girl, during the early stage of his medical career at Pontefract General Hospital, West Riding, Yorkshire. Smith concluded the probable number of Shipman's victims between 1971 and 1998 was 250. In total, 459 people died while under his care, but it is uncertain how many of those were Shipman's victims, as he was often the only doctor to certify a death.
The Shipman Inquiry also recommended changes to the structure of the General Medical Council.

The General Medical Council charged six doctors who signed cremation forms for Shipman's victims with misconduct, claiming they should have noticed the pattern between Shipman's home visits and his patients' deaths. All these doctors were found not guilty. Shipman's widow, Primrose Shipman, was called to give evidence about two of the deaths during the inquiry. She maintained her husband's innocence both before and after the prosecution.

In October 2005, a similar hearing was held against two doctors who worked at Tameside General Hospital in 1994, who failed to detect that Shipman had deliberately administered a "grossly excessive" dose of morphine.

A 2005 inquiry into Shipman's suicide found that it "could not have been predicted or prevented," but that procedures should nonetheless be re-examined.

In 2005, it came to light that Shipman might have stolen jewellery from his victims. Over £10,000 worth of jewellery had been found in his garage in 1998, and in March 2005, with Primrose Shipman pressing for it to be returned to her, police wrote to the families of Shipman's victims asking them to identify the jewellery.

Unidentified items were handed to the Assets Recovery Agency in May. In August the investigation ended: 66 pieces were returned to Primrose Shipman and 33 pieces, which she confirmed were not hers, were auctioned. The proceeds of the auction went to Tameside Victim Support. The only piece actually returned to a murdered patient's family was a platinum-diamond ring, for

which the family were able to provide a photograph as proof of ownership.

A memorial garden to Shipman's victims, called the Garden of Tranquillity, opened in Hyde Park (Hyde) on 30 July 2005.

Harold and Fred (They Make Ladies Dead) was a 2001 strip cartoon in Viz, also featuring serial killer Fred West. Extracts from the strip were subsequently merchandised as a coffee mug.

Shipman, a television dramatisation of the case, was made in 2002 and starred James Bolam in the title role. The case was also referenced in an episode of the 2003 television series Diagnosis: Unknown called "Deadly Medicine" (Season 2, Episode 17, 2003).

Shipman's activities also inspired D.A.W., an episode of the American TV series Law & Order: Criminal Intent. In it, the police investigate a physician who they discover has killed 200 of his patients.

Both The Fall and Jonathan King have released songs about Shipman. The Fall's song is, "What About Us?", from the 2005 album Fall Heads Roll.

King's song became controversial when, six months after its release, it was reported to be in Shipman's defence, urging listeners not to "fall for a media demon".

As of early 2009, families of the victims of Shipman are still seeking compensation for the loss of their loved ones.

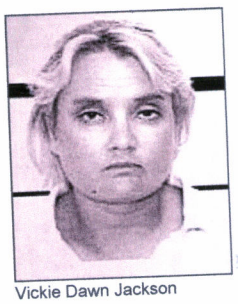
In September 2009, it was announced that letters written by Shipman during his prison sentence were to be sold at auction. Following complaints from victims' relatives and the media, the letters were removed from sale.

Angels of Death: The Female Nurses

BY *Katherine Ramsland*

It Doesnt Stop

Healthcare serial killers (now referred to as HCSKs or SHCKs) have become prominent in the media over the past decade, and yet around the world nurses are still killing patients:


Vickie Dawn Jackson

- In July 2002, Vickie Dawn Jackson, 36, was indicted in Texas for four counts of murder at Nocona General Hospital. Prosecutors believe that she injected lethal doses of mivacurium chloride, a muscle relaxant that temporarily stops a person from breathing, into elderly patients to end their lives. Several vials of that drug turned up missing. Ten bodies were exhumed to run tests and early in 2004, Jackson was indicted on three more counts of capital murder, one count of attempted murder, and one count of injury to a disabled person. She is suspected in as many as 25 deaths, according to Associated Press reports. Her trial is scheduled for October 2004.
- Christine Malèvre was charged with the murder of seven patients in 1997 and 1998 at a lung hospital in Mantes-la-Jolie, France. She confessed and said that she had wanted to help them to die out of compassion. In fact, according to Reuters, she said that she had assisted around 30 patients to die, but then she reduced that number to two and claimed she had done it at their request. Two others, she said, had been accidents. She had written a book about her acts, called *My Confessions*, apparently in an attempt to bring attention to the need for euthanasia for incurable and painful diseases. Families of her victims denied that those people had made any such request to have help ending their lives. Malèvre was sentenced in January 2003 for six of the deaths to a prison term of ten years. She is also permanently banned in France from working as a nurse.
- "Martha U" was chronicled in Paula Lampe's book, *The Mother Teresa Syndrome*, after being convicted in 1996 of murder in the deaths of four elderly patients. (Lampe is also detailing the de Berk case above in another book, and she offered her study for this article.) Martha U was suspected of killing nine patients. She had worked for 20 years in a geriatric nursing home and had used insulin to overdose the patients. In two cases, the patients apparently had angered her, one by showing anger himself and the other by throwing food at her. Nevertheless, she insisted that she had killed to end the patients' suffering. Yet she had murdered patients who were not as ill as others in the same room. If anything, Martha U was clearly inconsistent. She had made statements, according to Lampe, to the effect that she could not stand people dying, and she had resuscitated one patient who could have died peacefully. Lampe viewed her as having narcissistic personality disorder and a hero complex. None of the patients who died were considered to have been terminally ill. Martha U was a loner but also a compulsive helper. Immediately upon her arrest, she confessed.
- Lampe, living in the Netherlands, used Martha U's case to discuss the fine line between aggression and the desire to be needed. Those caregivers with self-esteem issues and other personal needs may go over the line. Lampe, a former nurse, said in the book that Martha U did not murder to help others but to end her own unbearable feelings of "transparency." In other words, she was satisfying her own needs rather than the needs of her patients. The "helping" aspect was actually a compulsion, and that kind of addiction can lead to murder. Referring to an FBI theory, Lampe indicated in a news report that "killing gives psychopaths who have such a low self-esteem a sense of power. That fact that they carry a secret, namely 'I have killed someone and nobody knows,' also gives them power."

Several professionals are now attempting to devise what could be termed a "prospective profile" of HCSKs, hoping to devise a constellation of red flags that colleagues can become aware of and use effectively. Lampe suggests that those nurses who seem compulsive, secretive, and consistently in the area of emergencies or Code Blues ought to be the focus of more scrutiny. Beatrice Crofts

Front Page
Serial Killers
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Yorker, associate professor of psychiatric mental health nursing at Georgia State University, has collected numerous cases and noted that many involved injection of non-controlled medications — perhaps an area of concern for hospitals. She, along with others in law enforcement, indicate that the following signals should be taken quite seriously:


Christine Malèvre

- Statistically, there is a higher death rate when the suspected person is on shift
- The suspect deaths were unexpected
- The death symptoms were also not expected, given the patient's illness or procedure
- The suspected person is always available to help
- He or she is often the last one seen with the victim
- The suspected person has moved around from one facility to another
- Other staff members give that person nicknames like "death angel"
- The person is overly interested in the death
- Other patients have complained about the person's treatment of them
- The person is secretive or has a difficult time with personal relationships
- The person has a history of some form of mental instability or depression

Identifying such people as soon as possible requires documenting patterns of behavior and finding physical evidence that links the suspected individual to the crimes. Unfortunately, intentional killers, as well as people who become addicted to killing as the result of a mercy killing or two, have the perfect arena in which to get away with murder for long periods of time. Hospitals are places of trust and the means to kill patients are readily available. In addition, medical murders are not easily detected. Stopping this phenomenon requires a sharp eye, an awareness that any care facility is vulnerable, and a desire to ensure that suspicious people be taken seriously.

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smh.com.au
The Sydney Morning Herald

'Party girl' nurse arrested over hospital deaths

Published: July 21, 2011 - 11:07AM

Detectives arrested a 26-year-old nurse on suspicion of murder over the deaths of three hospital patients given insulin-contaminated saline solution, British police said.

Rebecca Leighton worked at Stepping Hill Hospital in Stockport, where police were alerted last week to a batch of saline believed to have been deliberately tampered with.

The unexplained deaths of a 44-year-old woman and two men aged 84 and 71 are being linked to the contamination, while a fourth patient, a man in his 40s, remains critically ill.

"This morning, a 26-year-old woman was arrested on suspicion of murder. She remains in police custody for questioning. Inquiries are continuing," a spokesman for Greater Manchester Police said.

In total, 11 out of 14 patients originally affected by the contamination have survived.

Hospital chief executive Chris Burke told a press conference on Wednesday that staff were "shocked, horrified and angry" at the events.

"They are alarmed that a place that should be for care has become a crime scene," he said.

"This is a criminal act, perpetrated by someone with malicious intent. We do not believe it could have been anticipated."

On her Facebook profile Leighton describes herself as a "happy go lucky kinda gal", who "loves the wkend (if im not workin)".

AFP

A local nurses assistant has been charged with drugging seven of her elderly patients. Three of them died. Police are now investigating to see if murder charges can be filed.

"My mom says to me, 'I've done my grieving. God took him.' God didn't take him, mom. Somebody killed him," Suzie Yarger said.

Yarger believes her uncle, 68-year-old Bill Elgersma, may have been murdered by his nurses assistant.

"His life was taken."

Elgersma passed away in May. At the time the family believed he had a stroke.

He had spent the last seven years as a stroke victim at the Inland Christian home in Ontario -- a convalescent home.

But just weeks ago, 51-year-old Dameria Lawhorn, a certified nurses assistant who worked there, was charged with seven counts of elder abuse for allegedly overdosing seven patients with morphine. Three of them died, including Elgersma.

"They brought him to the hospital and he seized in the middle of the night. That is a horrible thing to go through," Yarger said.

Is Lawhorn an angel of mercy, putting people out of their misery? Ontario police and the coroner's office are still investigating.

All three victims were believed to have died of natural causes. Now they're taking a second look. But right now she is not charged with any murders.

Detective Alfredo Parra, Ontario Police: "At this point there is not enough evidence to support a murder charge."

David Goldstein: "Why?"

Detective Alfredo Parra, Ontario Police: "Because the patients that died; that evidence is gone."

Police were first alerted by paramedics, who were called to the scene because the patients were unresponsive. The three who died passed away at the hospital, days or, in one case, months later.

The four who survived were given a drug to treat morphine. That is when police started zeroing in on nurses and found that Lawhorn was on duty for all seven patients.

When they searched Lawhorn's locker, police say they found morphine. She denied sedating the seven, but police believe she did it to make the patients more cooperative.

Detective Alfredo Parra, Ontario Police: "It appears by sedating these victims her shift would be easier."

David Goldstein: "So she was giving them pills to make her job easier?"

Detective Alfredo Parra, Ontario Police: "It appears that way."

Lawhorn worked at Inland Christian for the past four years.

"This nursing assistant drugged seven patients. How does that happen?"

"There's no one available to speak with you at this time."

No one at the home wanted to speak about it. In a statement they said, "We are outraged and feel completely betrayed."

The same could be said of Suzie Yarger, who believes her uncle Bill could have lived a much longer life. "No matter how ill he was, he was in convalescent care. He wasn't in ICU. He wasn't at that death's door by any means. To me, it's still murder."

Lawhorn was fired from Inland Christian when she was arrested. She is in jail on $350,000 bail. The coroner's office is investigating to see if any body will be exhumed.

Nov 17, 2009 3:07 pm US/Pacific

Caregiver Investigated In Patients' Deaths

Reporting
David Goldstein
LOS ANGELES (CBS) —

e in patient

Charged with 10 deaths, she pleads no contest; prosecutors surprised

Associated Press

updated 10/3/2006 5:49:18 PM ET

SAN ANGELO, Texas — A former hospital nurse pleaded no contest Tuesday to killing 10 patients nearly six years ago by injecting them with a drug used to temporarily halt breathing.

Vickie Dawn Jackson, seen here entering a courtroom on Feb. 9, 2005, pleaded no contest Tuesday t

Vickie Dawn Jackson, 40, will be sentenced to life in prison, the maximum sentence she faced if she had been convicted by a jury.

Authorities have not offered a motive for the slayings.

Defense attorney Bruce Martin said Jackson decided to enter the plea because her adult daughter was on the state's witness list.

"She has never admitted guilt and she was never convicted by a jury," Martin said. "And her daughter never had to testify against her. Those things meant something to her."

Jackson was accused of killing the patients, including her third husband's grandfather, by injecting them with a drug used to stop breathing to allow insertion of a breathing tube.

Prosecutor said the deaths occurred during her night shifts at Nocona General Hospital in 2000 and 2001. More than 20 vials of the drug were missing and a syringe with traces of the drug was found in the nurse's garbage, they said.

Prosecutors were surprised by the plea, which came less than a week before Jackson's trial was scheduled to begin.

"Frankly, I've never been so surprised in a case in my life," said Jack McGaughey, district attorney for Montague, Clay and Archer counties, who had planned to call 58 witnesses. "The end result is as good as we could have gotten."

District Attorney Announces Filing of Capital Murder Charges in Hospital Deaths

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JANUARY 10, 2001
FOR IMMEDIATE RELEASE
Contacts: Joe Scott, Director of Communications
Sandi Gibbons, Public Information Officer
(213) 974-3525

LOS ANGELES -- District Attorney Steve Cooley announced today that a former Glendale Adventist Medical Center respiratory therapist has been charged with murdering six elderly patients who died in 1996 and 1997.

"After years of hard work, the combined efforts of both the Glendale Police Department and the District Attorney's Office have paid off in the filing of charges against Efren Salvidar," Cooley said.

He said the criminal complaint filed this morning in Glendale Superior Court alleges that all six victims were poisoned, a special circumstance under California law. The complaint also alleged a second special circumstance of multiple murder.

The District Attorney said his office will not make a determination on whether to seek the death penalty against the 31-year-old Saldivar (dob 9-30-69) until after a preliminary hearing of the evidence against him. Saldivar, of Tujunga, was arrested by Glendale police early Tuesday. He is being held without bail and is expected to be arraigned at 10 a.m. tomorrow in Division 1 of Glendale Superior Court, 600 E. Broadway, Glendale.

Cooley said that results of tests done on the exhumed bodies of the victims, coupled with recently discovered evidence found in Saldivar's home, led Deputy District Attorney Al MacKenzie to file the seven-count criminal complaint (case No. GA 044958). Besides, the six murder counts, Saldivar is charged with receiving stolen property, identified as a drug called Versed, which generally is used to induce sleep in patients.

The case has been under investigation by Glendale police since February 1998. In March 1998, Saldivar was questioned by police but released pending completion of the investigation.

MacKenzie said that during the investigation, 20 bodies of patients who had died at the hospital were exhumed and tissue samples were taken by the Los Angeles County coroner's office. Toxicological testing was performed on the tissue samples by Dr. Brian D. Andresen of Lawrence Livermore National Laboratory and the drug Pavulon was found

in the remains of the six victims named in the complaint filed today. The finding was reviewed by another leading toxicologist, Dr. Graham Jones, who concurred with Dr. Andresen's opinion.

All of the six deaths had been listed as suspicious, MacKenzie said. And of the six, five did not receive any Pavulon as part of their legitimate medical treatment prior to their deaths, he said.

The victims were identified as:

Jose Alfaro, 82, who was admitted on Jan. 2, 1997, and died two days later.
Salbi Asatryan, 75, admitted on Dec. 27, 1996, and died three days later.
Myrtle Brower, 84, admitted Aug. 18, 1997, and died 10 days later.
Balbino Castro, 87, admitted Aug. 6, 1997, and died nine days later.
Luina Schidlowski, 87, admitted Jan. 20, 1997, and died two days later.
Eleanora Schlegel, 77, admitted Dec. 30, 1996, and died three days later.
Cooley said that Deputy District Attorney Brian Kelberg, in charge of the Medico-Legal Section, worked closely with Glendale police in an advisory capacity during the investigation. The District Attorney said it was Kelberg who helped guide Glendale investigators through the delicate process of having the bodies exhumed and examined.

In late November, Cooley said he asked MacKenzie to take a look at the case. MacKenzie, skilled in prosecuting technical medical cases, had worked before with Glendale police in the successful prosecution of a Dr. Richard Boggs, a physician, and two others in an insurance fraud murder in which the victim's body had been cremated some time before the case was filed.

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Kaiser Papers
caregivers that kill

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http://www.latimes.com/news/printedition/la-000030503apr29.story

GRAVEYARD SHIFT

Digging Deep for 'Angel's' Terrible Toll
Glendale police endured nightmares and exhumed 20 bodies to find out what Efren Saldivar had been doing in the dark. 'Prepare to fail,' an expert warned.
By PAUL LIEBERMAN
TIMES STAFF WRITER

April 29 2002

A lieutenant told John McKillop, "Chief wants to see us."

McKillop was the sergeant of robbery-homicide. He hated "friend of chief" cases. They never did you any good.

There were three visitors in Chief Russell Siverling's office, led by a man nervously rubbing his head. The visitors were executives from Glendale Adventist Medical Center. The nervous one, Dave Nelson, had taken a call two weeks earlier from a man who identified himself only as "Grant." The caller said a "lady friend" at the hospital knew a respiratory therapist who had "helped a patient die fast." Maybe it was patients. Grant had been sketchy. He refused to name his lady friend, and he could not identify the killer. He suggested someone read him a list of the respiratory therapists--perhaps he'd recall the name. He left a pager number.

A hospital official beeped Grant the next day and read him the ledger of RTs, all 38 of them. He thought "Efren" sounded familiar.

Under other circumstances, the hospital might have written off the flaky caller. He admitted that he hoped to make money off his tip, even though his sponsor in Alcoholics Anonymous warned him that "smacks of blackmail." During other calls, about the only new tidbit he gave them was his last name, Brossus.
But hospital officials could not dismiss him. The year before, one of their own employees had alerted a supervisor to a rumor that a respiratory therapist on the graveyard shift, Efren Saldivar, was wielding a "magic syringe."

McKillop wanted to ask, "Why didn't you call us then?" Instead he said, "Here's what we do."

Minutes later, he was back at his desk, dialing a pager--and it did not belong to Grant Brossus.

On that afternoon--March 2, 1998--McKillop was about to get an education in a distinct breed of medical killer. "Angels of Death," they were called. People often saw them as agents of mercy. But McKillop would learn that there was nothing heavenly about these quiet executioners or how they often got away with murder for so long. It would take

Instead of answering, McKillop pulled out charts from the tests for Pavulon. "Every one of those indicates a positive, OK, for the drugs. It's just inundated throughout the body."

"Let's go back to '97," Currie said.

"OK."

"How many people do you think you personally--for lack of a better term--killed?"

"In '97, seriously slowed down," Saldivar said. " '97 was like a new leaf."

Saldivar was starting down a path of no return. He said, "The motivation is so flippant. I'm--I'm shameful to even say. . . ."

"How flippant can it be, Efren?"

"Oh, God, you can't believe how flippant. It was not for personal pleasure. It was not a rush. It was not--it wasn't any of your typical ideas."

"Well, what was it?" McKillop asked.

"Can we barter?"

"Like what? You want me to wash your car for you?"

"No. I want--I want to make my phone calls."

"Absolutely."

" 'Cause I want to call work. . . . People are out there standing. 'Where's Efren?' I've never missed a day."

"I understand."

"Now, as for my lawyer, it's not that I want him in here to stop you guys, but I want him to know that I'm in here."

"Is that what you were bartering with?"

"Yes."

They led him to a room with a phone, then stayed by the door, out of earshot. If he reached his lawyer, the message would be "Stop! NOW!" But it was early, when most people, lawyers included, were still at home, having their coffee.

Elsewhere at headquarters, other detectives were also on the phone, calling the 20 families that had been living with uncertainty since their loved ones' bodies were exhumed. The cops wanted to notify them of Saldivar's arrest before it hit the news.

Eleanora Schlegel's son, Larry, was in Chicago on a consulting job for the federal government. He had been with his mother two nights before her death, offering a New Year's Eve toast: "Hopefully, next year will be better." Now, his cell phone rang. Investigator Dan Hinojosa told him that Saldivar was being charged with six counts of murder. Hinojosa wanted to wait and tell him the rest in person.

"I said, 'Just tell me," recalled Schlegel. "He said that my mom was one of the six. Then I went back to the meeting."

In Glendale, when Saldivar was brought back to the cubicle, he was in a joking mood. He said into the thermostat, "Testing, testing."

He had not reached his lawyer. He was ready to talk about motive.

"It's not ethical or humane," he said. "I--I, in addition to others . . . had the role--responsibility--of staffing. We had too much work. We can't find nobody to come in."

"Just basically workload, too much work," McKillop said.

"It was not something that gave me joy," Saldivar said. "Only when I was only at my wits' end on the staffing, I'd look on the board. 'Who do we gotta get rid of?' "

It reminded McKillop how people clung to the belief that these "angels" killed to relieve suffering. A VA nurse in Massachusetts had just been convicted of murdering a patient so she could leave for a date. Saldivar might have talked of compassion in his first confession, but now it was about trimming his workload.

"What do you think was your highest year?" McKillop asked.

"It wasn't just at Glendale."

"What were the other hospitals?"

"Arcadia Methodist. Glendale Memorial."

In the first confession, he had spoken of letting patients die at other hospitals by not doing all he could to save them, "passive stuff." Now he was talking about killing with injections.

"Maybe two or three" at Arcadia Methodist, he said, where he moonlighted near the start of his career. "It has to be less than five."

He moonlighted at Glendale Memorial for three years.

"Over at Memorial, maybe 10."

McKillop asked for the "total in all the hospitals."

"I lost count after 60," Saldivar said. "And that was back in '94."

For so long, they had lived with the 40-some estimate in his earlier confession. Now he was saying the total was higher, much higher.

"I know it's over a hundred," he said.

Currie wanted to get more specific. How many more patients had he injected after he stopped counting at 60? Currie asked Saldivar to think backward from 1997, the year he had slowed down. "What about '96?"

"I don't know if it was 20, 30 or 40."

"OK, how about in '95?"

"Yeah. '95, same thing--30, 40."

" '94?"

Saldivar took off on a tangent. "It was a gradual thing. . . . I did it without thinking. I don't know if you ever shoplifted a piece of gum or something. You don't plan it. After that moment, you don't think about it for the rest of the day, or ever."

They had spent months analyzing the records of patients who died during one of his nine years, 1997, groping to pick names off a big board in "Club Med," deciding which to exhume. Now McKillop believed there might have been an easier way.

"If we went into '96, '95, '94," he said, "you could have thrown a dart."

"Uh-huh," Saldivar said.

The rest was mopping up. Why had he slowed in '97?

In part because he was happy being around Ursula Anderson on those long night shifts. "I would be with her and I wasn't worried about the patients."

What about Coyle, the pesky woman who had gone Code Blue but survived?

"Oh, her. Yeah, I did try. . . . I gave her, I think, a half dose. . . . Something in me just held back."

Mistakes Chronicled on Medicare Patients

By DUFF WILSON
Published: November 15, 2010

One of every seven Medicare beneficiaries who is hospitalized is harmed as a result of problems with the medical care there, according to a new study from the Office of Inspector General for the Department of Health and Human Services.

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The study said unexpected adverse events added at least $4.4 billion a year to government health costs and contributed to the deaths of about 180,000 patients a year.

In a single month, October 2008, the report estimated that some 134,000 Medicare patients experienced at least one adverse event, ranging from a temporary health setback to death, during a hospital stay. It said 44 percent of them were "clearly or likely preventable."

That study cited hospital infections as a major source of problems, but the inspector general's report found other events to be more common. The most frequent problems classified as adverse events, it said, were those related to medication, like excessive bleeding, followed by those related to patient care, like intravenous fluid overload, and those related to surgery and to infection.

The most serious events, like surgery on the wrong patient, amounted to less than 1 percent of the events tallied, according to Ruth Ann Dorrill, a team leader for the inspector general's study group. Those are known as "never events" — the National Quality Forum, a leading nonprofit group, said they "should never occur in a health care setting."

An American Hospital Association official, Nancy Foster, said the study highlighted the importance of improving procedures to prevent the medication errors and other problems described in the report.

"Hospitals and doctors and nurses are focused on preventing harm," Ms. Foster, the association's vice president of quality and patient safety, said on Monday. "But as this report suggests, we do have a ways to go before we are where we want our performance to be."

The study involved expert reviews of a representative sample of 780 patient files. It is scheduled to be posted on the inspector general Web site on Tuesday.

In a written response contained in the report, Dr. Carolyn M. Clancy, director of the federal Agency for Healthcare Research and Quality, said the adverse events were affecting

hospital patients at an “alarming rate” and promised to work to improve it.

Ms. Dorrill, a team leader for the study group, based in Dallas, said it was the seventh and most important of 10 reports on adverse events that the agency was doing in response to a health care law passed by Congress in 2006.

“There was a lot of momentum in the late ’70s, early ’80s when the patient safety movement started, and they wanted a progress check,” Ms. Dorrill said.

Kevin K. Golladay, the regional inspector general for evaluation and inspections, said: “We recommend a broader view of harm in a hospital.”

The report called for more oversight and financial incentives for hospitals to reduce errors. In its written response, Dr. Donald M. Berwick, administrator of the Centers for Medicare and Medicaid Services, said it would aggressively pursue recommendations to broaden the definition of adverse events, monitor and prevent them.

The problem had gained widespread attention with a 1999 report by the Institute of Medicine, titled “To Err is Human: Building a Safer Health System.” That report cited studies using different methodology to estimate 44,000 to 98,000 Americans die each year as a result of preventable medical errors in hospitals.

The inspector general’s study was the first to obtain a statistically valid national incidence rate for adverse events in a hospitalized population, the officials said. Previous estimates had extrapolated data from more limited studies.

A version of this article appeared in print on November 16, 2010, on page B3 of the New York edition.

Z Magazine
The Spirit of Resistance Lives

Do No Harm

July 2012

By **William Charney**

Do no harm," an important phrase in the delivery of healthcare, is not working. In fact, depending on the epidemiological approach and which data set one applies, medical errors, hospital-acquired infections (HAIs), and pharmaceutical errors combined are the leading, second, or third killer of Americans and Canadians annually. According to Joe and Terry Graedon of the People's Pharmacy in their new book, *Top Screwups Doctors Make And How to Avoid Them (Crown Publishing 2011),* medical mistakes are the leading cause of death when all the categories are counted, including: medical error, hospital-acquired infections, drug error, misdiagnosis, post operative infections, fatal drug reactions in Nursing Homes, unnecessary surgeries, and lethal blood clots in veins.

These errors, combined, amount to over 788,000 deaths per year—higher than heart disease (616,000) and cancer (562,000). According to the Centers for Disease Control (CDC), 2.4 million Americans died in 2007, making hospital intervention accountable for approximately one-third of all deaths in one year.

To get a truer picture of the scope of the problem is difficult as non-reporting rates are tremendously high—ranging from 60 to 95 percent. Added, as well, are the hundreds of thousands of patients who are harmed (morbidity), but not killed (mortality). Though the numbers must be understood in terms of the billion or so procedures that are done annually, still the existing numbers define an epidemic of harm. Some recent examples that made the headlines include:

> "Hospital uses wrong kidney for transplant"
> (*Los Angeles Times,* February 18, 2011)

"Surgical errors continue despite protocols"
(Archives of Surgery study as quoted by *NY Times*, October 19, 2010)

"Infection control lapses plague outpatient surgical centers"
(*Seattle Times,* June 9, 2010)

"Boy accidentally given double dose of medication at Tacoma Hospital" (*Seattle Times,* November12, 2010)

"X-Ray beam strays invisibly, harming instead of healing"
(*NY Times,* December 29, 2010)

"West Virginia Hospital Overradiated Brain Scan Patients"
(CT Procedures, *NY Times*, March 6, 2011)

As to the extent of the epidemic or errors, in the U.S., according to Joe and Terry Graedon:

- fatal drug reaction deaths in hospitals: 106,000
- fatal drug reaction deaths outpatient: 198,815
- fatal drug reaction deaths nursing homes: 41,652
- deaths related to misdiagnosis: 132,500
- healthcare acquired infection deaths in hospitals: 100,000
- deaths from infectious diarrhea in nursing
- homes: 16,500
- deaths from excessive radiation from CT
- scans: 29,500
- deaths from unnecessary surgery: 12,000
- deaths from surgical and post operative
- complications: 32,591
- lethal blood clots in veins (deep vein thrombosis and pulmonary embolism) leading to death: 119,000

And in Canada:

- 220,000-250,000 hospital-acquired infections every year in Canada leading to 8,000-12,000 deaths

(CUPE Report, 2011)

- 141,000-232,000 adverse events per year in Canadian acute care hospitals causing 24,000 preventable deaths (Canadian Medical Association, 2004)
- of 3,000 Canadian patients surveyed 10 percent reported a medical error, 24 percent reported a poorly coordinated case (*International Journal of Clinical Practice*, July, 2011)
- 1.5 million medication errors annually
- In Quebec from April to September 2011, 179,000 incidents including patient falls, medication error, and botched tests (Canadian Institute for Health Information)
- Reporting rates of medical error and adverse events range between 5 and 20 percent
- 1 out of 13 patients report an adverse event

The Systemic Causes vs. "Low Hanging Fruit"

Healthcare delivery has evolved improperly by building constructs that lead to medical error. Systemic causes that are directly linked by the science to patient harm have been systematically ignored and in some cases even legally blocked —as in the attempts by many states to pass regulation to improve staffing ratios. "For profit care" (U.S.), factory medicine (Canada), accountability issues (cannot get healthcare workers to wash their hands between patients) hierarchies in human relationship systems (bullying), over-reliance on technologies, stress, working conditions, staffing ratios in both clinical and non clinical departments, legal issues that conflict with safety issues, cost benefit issues that put safety on the negative side (spending side) rejecting the savings side of the equation—all considered systemic causes, all lead to adverse patient events but rarely, if ever, are confronted or changed as they are deemed too expensive and too extensive.

One such systemic factor is the profit motive. The *Journal of General Internal Medicine* published a study in March 2000 entitled "Hospital Ownership and Preventable Events" showing that patients in for-profit hospitals are 2 to 4 times more likely than patients at not-for-profit hospitals to suffer adverse events such as post surgical complications, delays in diagnosis, and treatment of an ailment. The editorial in the *Journal* also cited that for-profit hospitals lowered costs by cutting nursing services. Additionally, for-profit systems for blood collection cost 5 to 15 times more to collect, with 1,000 percent more blood wasted and higher transfusion-related infections, such as hepatitis.

Medicine in Canada has built in causes for errors, as well. More patients per hour, more operations per day, less rest between cases, less time with each individual patient. Lower staffing also can occur in factory medicine paradigms leading to more error. Provinces in Canada are balancing budgets by cutting support and ancillary hospital department staff, despite studies that show infection rates can and do increase with decreased staffing. According to a CUPE Report, staffing of support personnel is being cut 10 percent in Canadian health-care facilities. Numbers of beds are also being eliminated, causing overcrowding.

In the U.S, the number of staff to patients is not at acceptable levels. Only two states have regulations calling for a ratio guideline—California and Washington. Lack of staff increases the potential for medical error and has even been cited in the scientific literature as a direct link to error and infection. For each additional patient over-assigned to an RN, the risk of death increases by 7 percent for all patients. Patients in a hospital with a 1:8 nurse to patient ratio have a 31 percent greater risk of dying than patients in hospitals with a 1:4 nurse to patient ratio.

Longer shifts translate into higher numbers of medical error. Physicians in training who are scheduled to work long hours make 36 percent more serious medical errors with 5 times as many serious diagnostic errors. Fatigue-related error data is plentiful in the scientific literature. Fatigue-related preventable adverse events associated with the death of a patient increased by 300 percent for interns working more than 5 extended durations shifts per month.

Injury to healthcare workers (10 percent apply for workers compensation every year) contributes to medical error and compromises patient safety. Healthcare worker injury then becomes part of a loop that contributes directly to lack of staff per shift. Often an injured health-care worker is not replaced or is replaced with a

per-diem, who is not as fully aware of methods and that, too, can contribute to medical error.

Poor working conditions contribute directly to medical errors as they have a negative effect on staff. With 62 percent of nurses leaving the profession because of the physical demands of the job, working conditions are contributing to both negative patient outcomes and national and state nursing shortages. In 115 studies included in a 2003 review, evidence was provided that working conditions affect patient outcomes related to patient safety, the rate of medication errors, and the rate of recognition of such errors after they occur. Working conditions can be defined as ergonomics, patient developmental flows, staffing, workload, scheduling, autonomy, etc.

Bullying, too, has a direct and indirect effect on medical error and negative patient outcomes. It especially impairs nurses in their cognitive effectiveness. "If a new nurse in your hospital saw a senior physician placing a catheter, but not complying with the (hospital's) checklist, would the nurse speak up and would the physician comply? The answer is almost always, "There is no way the nurse would speak up." What other industry would accept a routine safety violation that is associated with the deaths of tens of thousands of patients and not be held accountable?" (Learning Accountability for Patient Outcomes," Pronovost, *JAMA* 2010).

A study of 1,700 nurses, physicians, clinical care staff, and administrators found fewer than 10 percent address behavior of colleagues that routinely includes trouble following directions, poor clinical judgment, and taking dangerous shortcuts. Specifically, 84 percent of MDs and 62 percent of RNs and other clinical care-providers had seen coworkers taking shortcuts that could be dangerous to patients. Fewer than 10 percent said they directly confronted their colleagues about their concerns and 1 in 5 MDs said they have seen harm come as a result. In one study, verbal abuse from physicians was noted by over 90 percent of participants and 76 percent witnessed negative nurse to nurse behavior. Nurses reported that 71 percent of those behaviors resulted in medical error, of which 29 percent resulted in death.

It must be noted that lack of real numbers hampers the research. The rates of under- and non-reporting are extremely high, running anywhere from 60 to 90 percent, depending on the study cited. There are 27 states in the U.S. with reporting regulations and none in Canada. But even in the states that have reporting regulations, there is a larger problem with compliance, funding, etc.

The legal system may be contributing to the overall problem of medical error. By not admitting error due to fear of liability and litigation, doing professional root cause analysis is compromised and therefore compromises care. There are also state and federal regulations that create legal mandates that can be in conflict with patient outcomes. A survey published in the *Annals of Internal Medicine* reported that nearly half of doctors say they have failed to report an impaired or incompetent colleague or serious medical error, though they were morally/legally bound to do so either by internal policy or state regulation. Accountability issues are constantly arising and being tested. Studies have shown that even getting health-care workers to wash hands between patients or after leaving bathrooms is not enforced and there are low compliance rates.

Interestingly, there has been a consensus that technology is the panacea. It is and is not. Computerized Physician Order Entry (CPOE) is being implemented at a huge financial cost. Smart technologies in health care are being designed to intervene in administration errors, including smart infusion pumps and bar code verification systems. But, according to a recent study, 98,000 people end up in emergency rooms every year (mostly elderly) due to medication error. Though new technology has shown good reductions of error, especially in the administration of pharmaceuticals, we must be careful not to adopt them as curealls, but more as support tools.

Attaching a cost-benefit analysis to medical error is a challenge, especially when health-care facilities do not understand the true science of the cost-benefit of medical error and many reject the premise of "indirect cost." This can lead to miscalculations and decision errors. For example, the system sees expenditures on prevention as a cost. But the Society of Actuaries has stated that medical errors are costing 20 billion a year. Bed sores alone account for a cost of 3.9 billion annually. The cost per patient of medical error can be as high as $20,000 per bed (using the American Hospital Association's data of one million hospital beds in the U.S.).

What Are The Problems?

One of the premises of this article is to look at the problem of medical errors not necessarily from a clinical perspective, but from a social science and political framework. This allows for a reasonable discussion of systemic causes, the concept in which health-care delivery is designed and the manner in which those design

characteristics play a pivotal role in causing error and infection. Unless this type of analysis takes place, it is believed that the health-care community will miss the underlying reasons why error and infections are prevalent and only allow for the "low hanging fruit" (checklists, computerization, IT) to be selected for remediation.

The social sciences deal with the inter-relationships within a societal framework. A social science approach combines humanism, relativism, demography, communication, behavior (interactions), and other approaches in a broad-based theoretical analysis instead of just constructing empirically falsifiable theories. We believe that each health-care delivery system and its partner hospitals are a society within itself where departments interact much in the same way as different groups within a society interact. When dysfunction occurs there is a current that reverberates through the entire system of delivery of care.

The American Hospital Association, a group that is employer owned, made a laudable case and embarked on the "100,000 Campaign." This shed light on a situation that was not on the national radar. Much was done and, in some cases, decreases in categories were achieved. However, the weakness of this effort was the voluntary participation of each individual health-care system designing its own definition of what is considered a medical error or infection. At present, 27 states in the U.S. have reporting regulations, but the compliance rates are abysmally low, under-funded, and few consequences were built into the regulations. There are no existing regulations in Canada, either federally or provincially, that require hospitals to report medical error or infection other than internal policies.

Changing systemically will be expensive, but the numbers actually speak for themselves—if they are disseminated impartially. If, for example, increasing staff would prevent X numbers of medical errors and/or infections, the dollar costs of expanding labor would be offset by decreasing costs of errors and infections. A bed sore can cost $14,000 per case. If we take that number, preventing three bed sores can pay for an extra full-time employee, which would theoretically prevent the bed sores by turning the patient more often.

The Hippocratic Oath, "do no harm," and the vision statements are posted at all hospital entrances. Yet, recently, a 40-year-old man was admitted for a routine shoulder procedure. After he was given too much anesthesia, he became oxygen-deprived and brain death occurred. In order to avoid the reporting regulation (reporting error within 24 hours of admission), the hospital put the patient on life

support to keep him alive for one more day so the 24 hour reporting rule could be circumvented.

Compromises in patient safety have an ethical component. A 3 percent error rate might seem low, but then add a 3 percent hospital-acquired infection rate and a 3 percent drug error rate, and you have a 9 percent error rate—almost 1 out of 10 hospital patients. Patient safety committees, medical ethics committees, and risk management committees exist to deal with problems, but they are often functioning within existing frameworks of systemic dysfunction. They are then asked to break free of the constraints and pressures that are resistant to change during one-hour weekly meetings.

What are the performance achievements of healthcare in the U.S. and Canada? The U.S. ranks 20th in the world and Canada 9th in health rating inclusiveness, quality of service, and perceived health care between highest and lowest incomes. The Bertelsmann Stiftung Foundation of Germany in a 2011 report entitled "Social Justice in the OECD," noted that in the U.S. has the most expensive care per person ($7,960) while Canada has the fifth most expensive ($4,363). Counter-intuitiveness aside, being an expensive health-care delivery system does not necessarily deliver quality health care and in the rush to treat as many people as possible, something gets overlooked in the Western medicine model.

Building The Case: A Temporary Conclusion

The social science perspective encourages the formation of a social movement on issues of such important societal impact as public health and national patient safety. A social movement would require health-care workers of all types, working with public health officials, legislatures, trade unionists, government agencies, and funding agencies, to write a plan of action to challenge the status quo of medical error based on the systemic causes listed here: staff ratios, shift work, bullying, overbooking and overcrowding, reporting errors, accountability where little or none exists, solving the contradictions between legal need, patient safety, and on and on.

The healthcare delivery system requires systemic change. We cannot even at this point count with any reliability on the number of errors due to lack of reporting, under-reporting, and self-definition reporting. There is no federal reporting rule and, in the states that have rules on reporting (only 27 at present), the language is

weak and most states report low compliance. In Canada, there is no federal or provincial reporting rule at present for medical error. Hospitals are reluctant to release error and infection information. Hospitals that do report are guided by self-reporting standards that are unreliable for consumers. And then, of course, there is the fact that we are asking the people who are responsible for the very conditions that have produced this alarming threat to human life to fix the problem.

Health care is sick and needs doctoring. The damages being done cry out for systemic change.

APPENDIX 1: MORE DATA

- **Britain in a report to Parliament 2008, 11,000 deaths per year due to medical error**
- **Germany, with 1/4th of the U.S. population reported 17,000 deaths per year due to medical error**
- **15,000 Medicare patients die each month in part due to hospital care including such events as bedsores, thinners, infections and mis-medicating (DHHS, Office of Inspector General Report, quoted in U.S.A Today, Nov 16th 2010, p A1)**
- **Of the one million Medicare patients discharged each year, 134,000 were harmed by medical care and 180,000 die each year(Inspector General's report, 2010)**
- **North Carolina study in 2008, 25.1 injuries per 100 patient admissions are injured due to medical error**
- **1/3 of all patient admissions result in some form of medical error (Human Affairs, 2011)**
- **40 wrong site surgeries occur every week in the U.S. (Human Affairs, 2011)**
- **Hospital deaths caused by MRSA in U.S. 1999-2001, sixth leading cause of death in U.S. costing 50 billion (Willems, G Emerging Infectious**
- **Disease, volume 13 no 12, December 2007, www.cdc.gov/eid)**
- **1.14 million medical errors out of 37 million hospitalizations in medicare population from 2000-2002 or 3.1 percent (Health Grades 2004)**
- **According to FDA data 1.3 million patients are injured per year from medication errors**

Encyclopedia

Adjustment disorder
Gale Encyclopedia of Mental Disorders
2003 | Scherstuhl, Holly

Adjustment disorder

Definition

An adjustment disorder is a type of mental disorder resulting from maladaptive, or unhealthy, responses to stressful or psychologically distressing life events. This low level of adaptation then leads to the development of emotional or behavioral symptoms.

Description

Often, a person experiences a stressful event as one that changes his or her world in some fundamental way. An adjustment disorder represents significant difficulty in adjusting to the new reality.

The stressful events that precipitate an adjustment disorder vary widely. They may include the loss of a job; the end of a romantic relationship; a life transition such as a career change or retirement; or a serious accident or sickness. Some are acute "one-time" stressors, such as relocating to a new area, while others are chronic, such as caring for a child with **mental retardation** .

Psychiatrists have disagreed about the validity of the **diagnosis** of adjustment disorder, largely because of its lack of specificity. What qualifies as a stressful event, and what is an abnormal response to it? While adjustment disorders are more difficult to quantify than other mental disorders, many researchers consider the category a useful one for two reasons: 1) an adjustment disorder may be an early sign of a major mental disorder and allow for early treatment and **intervention** ; 2) adjustment disorders are "situational" or "reactive"; they do not imply that the patient has an underlying **brain** disease.

Causes and symptoms

Causes

The ***Diagnostic and Statistical Manual of Mental Disorders*** , which is the basic reference work consulted by mental health professionals, included an important change in its most recent version, the *DSM-IV-TR*, with regard to the criteria for adjustment disorder. In the previous edition, the identifiable stressor was described as being "psychosocial," a category that excludes physical illnesses and natural disasters. In the *DSM-IV-TR*, the word "psychosocial" was deleted in order to make the point that any stressful event can lead to an adjustment disorder. It is important to recognize, however, that while adjustment disorders are triggered by external stressors, the symptoms result from the person's interpretation of and adaptation to the stressful event or circumstances. Beliefs, perceptions, fears, and expectations influence the development of an adjustment disorder.

People with chronic physical illnesses appear to have an increased risk of developing adjustment disorders, particularly one with depressed mood. This connection has been demonstrated among cancer patients. The relationship between chronic pain (as is commonly experienced by cancer patients) and depressive symptoms is still being studied.

Symptoms

DSM-IV-TR states that the symptoms of an adjustment disorder must appear within three months of a stressor; and that they must meet at least one of the following criteria: 1) the distress is greater than what would be expected in response to that particular stressor; 2) the patient experiences significant impairment in social relationships or in occupational or academic settings. Moreover, the symptoms cannot represent bereavement, as normally experienced after the death of a loved one.

DSM-IV-TR specifies six subtypes of adjustment disorder, each with its own predominant symptoms:

- With depressed mood: The chief manifestations are feelings of sadness and depression, with a sense of accompanying hopelessness. The patient may be tearful and have uncontrollable bouts of crying.
- With anxiety: The patient is troubled by feelings of apprehension, nervousness, and worry. He or she may also feel jittery and unable to control his or her thoughts of doom. Children with this subtype may express fears of separation from parents or other significant people, and refuse to go to sleep alone or attend school.
- With mixed anxiety and depressed mood: The patient has a combination of symptoms from the previous two subtypes.
- With disturbance of conduct: This subtype involves such noticeable behavioral changes as shoplifting, truancy, reckless driving, aggressive outbursts, or sexual promiscuity. The patient disregards the rights of others or previously followed rules of conduct with little concern, guilt or remorse.
- With mixed disturbance of emotions and conduct: The patient exhibits sudden changes in behavior combined with feelings of depression or anxiety. He or she may feel or express guilt about the behavior, but then repeat it shortly thereafter.
- Unspecified: This subtype covers patients who are adjusting poorly to **stress** but who do not fit into the other categories. These patients may complain of physical illness and pull away from social contact.

Adjustment disorders may lead to **suicide** or suicidal thinking. They may also complicate the treatment of other diseases when, for instance, a sufferer loses interest in taking medication as prescribed or adhering to **diets** or exercise regimens.

An adjustment disorder can occur at any stage of life.

Demographics

Adjustment disorder appears to be fairly common in the American population; recent figures estimate that 5%–20% of adults seeking outpatient psychological treatment suffer from one of the subtypes of this disorder. As many as 70% of children in psychiatric inpatient settings may be diagnosed with an adjustment disorder. In a 1991 questionnaire that was sent to child psychiatrists, 55% admitted to giving children the diagnosis of an adjustment disorder to avoid the **stigma** associated with other disorders.

Women are diagnosed with adjustment disorder twice as often as men, while in clinical samples of children and adolescents, boys and girls were equally likely to be diagnosed with an adjustment disorder. Nolen-Hoeksema, a researcher who has conducted numerous studies on gender differences in depression, has argued that women over the age of 15 exhibit a more depressive temperament than men. She theorizes that women are more likely to respond to depression in ways that make the disorder worse and prolong it. Her findings appear to have some applicability to adjustment disorder with depressed mood.

There are no current studies of differences in the frequency of adjustment disorder in different racial or ethnic groups. There is, however, some potential for bias in diagnosis, particularly when the diagnostic criteria concern abnormal responses to stressors. *DSM-IV-TR* specifies that clinicians must take a patient's cultural background into account when evaluating his or her responses to stressors.

Diagnosis

Adjustment disorders are almost always diagnosed as the result of an interview with a **psychiatrist** . The psychiatrist will take a history, including identification of the stressor that has triggered the adjustment disorder, and evaluate the patient's responses to the stressor. The patient's primary physician may give him or her a thorough physical examination to rule out a previously undiagnosed medical illness.

The American Psychiatric Association considers adjustment disorder to be a residual category, meaning that the diagnosis is given only when an individual does not meet the criteria for a major mental disorder. For example, if a person fits the more stringent criteria for **major depressive disorder** , the diagnosis of adjustment disorder is not given. If the patient is diagnosed with an adjustment disorder but continues to have symptoms for more than six months after the stressor and its consequences have ceased, the diagnosis is changed to another mental disorder. The one exception to this time limit is situations in which the stressor itself is chronic or has enduring consequences. In that case, the adjustment disorder would be considered chronic and the diagnosis could stand beyond six months.

The diagnosis of adjustment disorder represents a particular challenge to clinicians because it has no checklist of specific and observable symptoms. The diagnosis is instead based on a broad range of emotional and behavioral symptoms that can vary widely in appearance and severity. The lack of a diagnostic checklist does in fact distinguish adjustment disorders from either **post-traumatic stress disorder** or **acute stress disorder** . All three require the presence of a stressor, but the latter two define the extreme stressor and specific patterns of symptoms. With adjustment disorder, the stressor may be any event that is significant to the patient, and the disorder may take very different forms in different patients.

Adjustment disorders must also be distinguished from **personality disorders** , which are caused by enduring personality traits that are inflexible and cause impairment. A personality disorder that has not yet surfaced may be made worse by a stressor and may mimic an adjustment disorder. A clinician must separate relatively stable traits in a patient's personality from passing disturbances. In some cases, however, the patient may be given both diagnoses. Again, it is important for psychiatrists to be sensitive to the role of cultural factors in the presentation of the patient's symptoms.

If the stressor is a physical illness, diagnosis is further complicated. It is important to recognize the difference between an adjustment disorder and the direct physiological effects of a general medical condition (such as the usual temporary functional impairment associated with chemotherapy). This distinction can be clarified through communication with the patient's physician or by education about the medical condition and its treatment. For some individuals, however, both may occur and reinforce each other.

Treatments

There have been few research studies of significant scope to compare the efficacy of different treatments for adjustment disorder. The relative lack of outcome studies is partially due to the lack of specificity in the diagnosis itself. Because there is such variability in the types of stressors involved in adjustment disorders, it has proven difficult to design effective studies. As a result, there is no consensus regarding the most effective treatments for adjustment disorder.

Psychological and social interventions

There are, however, guidelines for effective treatment of people with adjustment disorders. Effective treatments include stress-reduction approaches; therapies that teach coping strategies for stressors that cannot be reduced or removed; and those that help patients build support networks of friends, family, and people in similar circumstances. **Psychodynamic psychotherapy** may be helpful in clarifying and interpreting the meaning of the stressor for a particular patient. For example, if the person is suffering from cancer, he or she may become more dependent on others, which may be threatening for people who place a high value on self-sufficiency. By exploring those feelings, the patient can then begin to recognize all that is not lost and regain a sense of self-worth.

Therapies that encourage the patient to express the fear, anxiety, rage, helplessness and hopelessness of dealing with the stressful situation may be helpful. These approaches include journaling, certain types of art therapy, and movement or dance therapy. **Support groups** and **group therapy** allow patients to gain perspective on the adversity and establish relationships with others who share their problem. Psychoeducation and medical crisis counseling can assist individuals and families facing stress caused by a medical illness.

Such types of brief therapy as **family therapy** , **cognitive-behavioral therapy** , solution-focused therapy, and **interpersonal therapy** have all met with some success in treating adjustment disorder.

Medications

Clinicians do not agree on the role of medications in treating adjustment disorder. Some argue that medication is not necessary for adjustment disorders because of their brief duration. In addition, they maintain that medications may be counterproductive by undercutting the patient's sense of responsibility and his or her motivation to find effective solutions. At the other end of the spectrum, other clinicians maintain that medication by itself is the best form of treatment, particularly for patients with medical conditions, those who are terminally ill, and those resistant to **psychotherapy** . Others advocate a middle ground of treatment that combines medication and psychotherapy.

Alternative therapies

Spiritual and religious counseling can be helpful, particularly for people coping with existential issues related to physical illness.

Some herbal remedies appear to be helpful to some patients with adjustment disorders. For adjustment disorder with anxiety, a randomized controlled trial found that patients receiving Euphytose (an herbal preparation containing a combination of plant extracts including Crataegus, Ballota, Passiflora, Valeriana, Cola, and Paullinia) showed significant improvement over patients taking a placebo.

Prognosis

Most adults who are diagnosed with adjustment disorder have a favorable prognosis. For most people, an adjustment disorder is temporary and will either resolve by itself or respond to treatment. For some, however, the stressor will remain chronic and the symptoms may worsen. Still other patients may develop a major depressive disorder even in the absence of an additional stressor.

Studies have been conducted to follow up on patients five years after their initial diagnosis. At that time, 71% of adults were completely well with no residual symptoms, while 21% had developed a major depressive disorder or alcoholism. For children aged 8–13, adjustment disorder did not predict future psychiatric disturbances. For adolescents, the prognosis is grimmer. After five years, 43% had developed a major psychiatric disorder, often of far greater severity. These disorders included **schizophrenia** , **schizoaffective disorder** , major depression, substance use disorders, or personality disorders. In contrast with adults, the adolescents' behavioral symptoms and the type of adjustment disorder predicted future mental disorders.

Researchers have noted that once an adjustment disorder is diagnosed, psychotherapy, medication or both can prevent the development of a more serious mental disorder. Effective treatment is critical, as adjustment disorder is associated with an increased risk of suicide attempts, completed suicide, substance abuse, and various unexplained physical complaints. Patients with chronic stressors may require ongoing treatment for continued symptom management. While patients may not become symptom-free, treatment can halt the progression toward a more serious mental disorder by enhancing the patient's ability to cope.

Prevention

In many cases, there is little possibility of preventing the stressors that trigger adjustment disorders. One preventive strategy that is helpful to many patients, however, is learning to be proactive in managing ordinary life stress, and maximizing their problem-solving abilities when they are not in crisis.

See also Anxiety-reduction techniques; Bodywork therapies; Cognitive retraining techniques; Generalized anxiety disorder; Cognitive problem-solving skills training

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ORGANIZATIONS

National Institute of Mental Health. 6001 Executive Boulevard, Rm. 8184, MSC 9663, Bethesda, MD 20892-9663. (301) 443-4513. <http://nimh.nih.gov>.

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Commentary: The Case Against Physician-Assisted Suicide: For the Right to End-of-Life Care

By Herbert Hendin, M.D. | February 1, 2004
Dr. Hendin is professor of psychiatry at New York Medical College and medical director of the American Foundation for Suicide Prevention. He is the author of Seduced by Death: Doctors, Patients, and Assisted Suicide and co-edited The Case Against Assisted Suicide: For the Right to End-of-Life Care with Kathleen Foley, M.D. His work was cited by the U.S. Supreme Court in its decision that there was no constitutional right to assisted suicide.

Euthanasia is a word coined from Greek in the 17th century to refer to an easy, painless, happy death. In modern times, however, it has come to mean a physician's causing a patient's death by injection of a lethal dose of medication. In physician-assisted suicide, the physician prescribes the lethal dose, knowing the patient intends to end their life.

Giving medicine to relieve suffering, even if it risks or causes death, is not assisted suicide or euthanasia; nor is withdrawing treatments that only prolong a painful dying process. Like the general public, many in the medical profession are not clear about these distinctions. Terms like assisted death or death with dignity blur these distinctions, implying that a special law is necessary to make such practices legal--in most countries they already are.

Compassion for suffering patients and respect for patient autonomy serve as the basis for the strongest arguments in favor of legalizing physician-assisted suicide. Compassion, however, is no guarantee against doing harm. A physician who does not know how to relieve a patient's suffering may compassionately, but inappropriately, agree to end the patient's life.

Patient autonomy is an illusion when physicians are not trained to assess and treat patient suffering. The choice for patients then becomes continued agony or a hastened death. Most physicians do not have such training. We have only recently recognized the need to train general physicians in palliative care, training that teaches them how to relieve the suffering of patients with serious, life-threatening illnesses. Studies show that the less physicians know about palliative care, the more they favor assisted suicide or euthanasia; the more they know, the less they favor it.

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What happens to autonomy and compassion when assisted suicide and euthanasia are legally practiced? The Netherlands, the only country in which assisted suicide and euthanasia have had legal sanction for two decades, provides the best laboratory to help us evaluate what they mean in actuality. The Dutch experience served as a stimulus for an assisted-suicide law in Oregon--the one U.S. state to sanction it.

I was one of a few foreignresearchers who had the opportunity to extensively study the situation in the Netherlands, discuss specific cases with leading Dutch practitioners and interview Dutch government-sponsored euthanasia researchers about their work. We all independently concluded that guidelines established by the Dutch for the practice of assisted suicide and euthanasia were consistently violated and could not be enforced. In the guidelines, a competent patient who has unrelievable suffering makes a voluntary request to a physician. The physician, before going forward, must consult with another physician and must report the case to the authorities.

Concern over charges of abuse led the Dutch government to undertake studies of the practice in 1990, 1995 and in 2001 in which physicians' anonymity was protected and they were given immunity for anything they revealed. Violations of the guidelines then became evident. Half of Dutch doctors feel free to suggest euthanasia to their patients, which compromises the voluntariness of the process. Fifty percent of cases were not reported, which made regulation impossible. The most alarming concern has been the documentation of several thousand cases a year in which patients who have not given their consent have their lives ended by physicians. A quarter of physicians stated that they "terminated the lives of patients without an explicit request" from the patient. Another third of the physicians could conceive of doing so.

An illustration of a case presented to me as requiring euthanasia without consent involved a Dutch nun who was dying painfully of cancer. Her physician felt her religion prevented her from agreeing to euthanasia so he felt both justified and compassionate in ending her life without telling her he was doing so. Practicing assisted suicide and euthanasia appears to encourage physicians to think they know best who should live and who should die, an attitude that leads them to make such decisions without consulting patients--a practice that has no legal sanction in the Netherlands or anywhere else.

Compassion is not always involved. In one documented case, a patient with disseminated breast cancer who had rejected the possibility of euthanasia had her life ended because, in the physician's words: "It could have taken another week before she died. I just needed this bed."

Since the government-sanctioned Dutch studies are primarily numerical and categorical, they do not examine the interaction of physicians, patients and families that determines the decision for euthanasia. Other studies conducted in the Netherlands have indicated how voluntariness is compromised, alternatives not presented and the criterion of unrelievable suffering bypassed. A few examples help to illustrate how this occurs:

A wife, who no longer wished to care for her sick, elderly husband, gave him a choice between euthanasia and admission to a home for the chronically ill. The man, afraid of being left to the mercy of strangers in an unfamiliar place, chose to have his life ended; the doctor although aware of the coercion, ended the man's life.

A healthy 50-year-old woman, who lost her son recently to cancer, refused treatment for her depression and said she would accept only help in dying. Her psychiatrist assisted in her suicide within four months of her son's death. He told me he had seen her for a number of sessions when she told him that if he did not help her she would kill herself without him. At that point, he did. He seemed on the one hand to be succumbing to emotional blackmail and on the other to be ignoring the fact that even without treatment, experience has shown that time alone was likely to have affected her wish to die.

Another Dutch physician, who was filmed ending the life of a patient recently diagnosed with amyotrophic lateral sclerosis, says of the patient, "I can give him the finest wheelchair there is, but in the end it is only a stopgap. He is going to die, and he knows it." That death may be years away but a physician with this attitude may not be able to present alternatives to this patient.

The government-sanctioned studies suggest an erosion of medical standards in the care of terminally ill patients in the Netherlands when 50% of Dutch cases of assisted suicide and euthanasia are not reported, more than 50% of Dutch doctors feel free to suggest euthanasia to their patients, and 25% admit to ending patients' lives without their consent.

Euthanasia, intended www.psychiatrictimes.com/display/article/10168/1358126originally for the exceptional case, became an accepted way of dealing with serious or terminal illness in the Netherlands. In the process, palliative care became one of the casualties, while hospice care has lagged behind that of other countries. In testimony given before the British House of Lords, Zbigniew Zylicz, one of the few palliative care experts in the Netherlands, attributed Dutch deficiencies in palliative care to the easier alternative of euthanasia.

Acknowledging their deficiencies in end-of-life care, the Dutch government has made an effort to stimulate palliative care at six major medical centers throughout the country in the past five years in the hope of improving the care of dying patients. Simultaneously, initiatives for training professionals caring for terminally ill patients were undertaken. More than 100 hospices were also established.

Even if the Dutch experience suggests that engaging physicians in palliative care is harder when the easier option of euthanasia is available, for a significant number such training has become a welcome option. A number of physicians who received the training have publicly expressed their regrets over having previously euthanized patients because they had not known of any viable option. Such expressions of regret would have been inconceivable five years ago.

Developments of the last five years may be having a measurable effect. In contrast to a 20% increase in euthanasia cases from 1991 to 1995, the number of euthanasia cases in 2001 was no greater than in 1995. If education of Dutch doctors by palliative care instructors is successful, a gradual reduction in the number of cases of assisted suicide, euthanasia and involuntary euthanasia cases will be a measure of that success.

Oregon is experiencing many of the same problems as the Netherlands but is not doing nearly as much to combat them. Although legalizing only assisted suicide and not euthanasia, Oregon's law differs from the Dutch in one respect that virtually builds failure into the law.

Intolerable suffering that cannotbe relieved is not a basic requirement for assisted suicide in Oregon as itstill is in the Netherlands. Simply having a diagnosis of terminal illness with a prognosis of less than sixmonths to live is considered a sufficient criterion. This shifts the focus from relieving the suffering of dyingpatients desperate enough to consider hastening death to meeting statutory requirements for assisted suicide. It encourages physicians to go through the motions of offering palliative care, providing serious psychiatric consultation or making an effort to protect those vulnerable to coercion.

In Oregon, when a terminally ill patient makes a request for assisted suicide, physicians are required to point out that palliative care and hospice care are feasible alternatives. They are not required, however, to be knowledgeable about how to relieve either physical or emotional suffering in terminally ill patients. Without such knowledge, the physician cannot present feasible alternatives. Nor are physicians who lack this knowledge required to refer any patient requesting assisted suicide for consultation with a physician knowledgeable about palliative care.

The inadequacy of palliative care consultation in Oregon was underscored by a survey of Oregon physicians who received the first 142 requests for assisted suicide since the law went into effect. In only 13% of cases was a palliative care consultation recommended, and we do not know how many of these recommendations were actually implemented.

Two Oregon cases illustrate how compromised the offer of palliative care can become. The first patient, referred to by her physician as "Helen," was the first known case of physician-assisted suicide in the state. The case was publicized by the Compassion in Dying Federation, an advocacy organization for physician-assisted suicide.

Helen, an Oregon woman in her mid-80s, had metastatic breast cancer and was in a home-hospice program. Her physician had not been willing to assist in her suicide for reasons that were not specified and a second physician refused on the grounds that she was depressed.

Helen called Compassion in Dying and was referred to a physician who would assist her. After her death, a Compassion in Dying press conference featured a taped interview said to have been made with Helen two days before her death. In it, the physician tells her that it is important she understand that there are other choices she could make that he will list for her--which he does in only three sentences covering hospice support, chemotherapy and hormonal therapy.

Doctor: There is, of course, all sorts of hospice support that is available to you. There is, of course, chemotherapy that is available that may or may not have any effect, not in curing your cancer, but perhaps in lengthening your life to some extent. And there is also available a hormone which you were offered before by the oncologist, tamoxifen(Drug information on tamoxifen), which is not really chemotherapy but would have some possibility of slowing or stopping the course of the disease for some period of time.

Helen: Yes, I don't want to take that.

Doctor: All right, OK, that's pretty much what you need to understand.

A cursory, dismissive presentation of alternatives precludes any autonomous decision by the patient. Autonomy is further compromised by the failure to mandate psychiatric evaluation. Such an evaluation is the standard of care for patients who are suicidal, but the Oregon law does not require it in cases of assisted suicide.

Physicians must refer patients to licensed psychiatrists or psychologists only if they believe the patients' judgment is impaired. A diagnosis of depression per se is not considered a sufficient reason for such a referral. However, as with other individuals who are suicidal, patients who desire an early death during a serious or terminal illness are usually suffering from a treatable depressive condition. In any case, studies have also shown that non-psychiatric physicians are not reliably able to diagnose depression, let alone to determine whether the depression is impairing judgment.

Not all of the factors justifying a psychiatric consultation center on current depression. Patients requesting a physician's assistance in suicide are usually telling us that they desperately need relief from their mental and physical suffering and that without such relief they would rather die. When they are treated by a physician who can hear their desperation, understand their ambivalence, treat their depression and relieve their suffering, their wish to die usually disappears.

The psychiatric consultation as envisioned by the Oregon law is not intended to deal with these considerations. It is only concerned with the more limited issue of a patient's capacity to make the decision for assisted suicide to satisfy the requirement of informed consent. The story of Joan Lucas, whose suicide was also facilitated and publicized by Compassion in Dying, points out how such a gatekeeper role encourages seeking psychological or psychiatric consultation to protect doctors, rather than patients.

Lucas, an Oregon patient with amyotrophic lateral sclerosis, attempted suicide. Paramedics were called to her house, but her children sent them away, explaining, "We couldn't let her go to the ambulance. They would have resuscitated her."

Lucas survived her attempt and was assisted in suicide 18 days later by a physician who gave interviews about the case to an Oregon newspaper on condition of anonymity. He stated that after talking with attorneys and agreeing to help aid Lucas in her death, he asked her to undergo a psychological examination. "It was an option for us to get a psychological or psychiatric evaluation," he told the newspaper. "I elected to get a psychological evaluation because I wished to cover my ass. I didn't want there to be any problems."

The doctor and the family found a cooperative psychologist who asked Lucas to take the Minnesota Multiphasic Personality Inventory (MMPI). Because it was difficult for Joan to travel to the psychologist's office, her children read the true-false questions to her at home. The family found the questions funny, and Joan's daughter described the family as "cracking up over them." Based on these test results, the psychologist concluded that whatever depression Joan had was directly related to her terminal illness--a completely normal response. His opinion is suspect, the more so because while he was willing to give an opinion that would facilitate ending Joan's life, he did not feel it was necessary to see her first.

Data from patient interviews, surveys of families of patients receiving end-of-life care in Oregon, surveys of physicians' experience and data from the few cases where information has been made available suggest the inadequacy of end-of-life care in Oregon.

Oregon physicians have been given authority without being in a position to exercise it responsibly. They are expected to inform patients that alternatives are possible without being required to be knowledgeable enough to present those alternatives in a meaningful way, or to consult with someone who is. They are expected to evaluate patient decision-making capacity and judgment without a requirement for psychiatric expertise or consultation. They are expected to make decisions about voluntariness without having to see those close to the patient who may be exerting avariety of pressures, from subtle to coercive. They are expected to do all of this without necessarily knowing the patient for longer than 15 days. Since physicians cannot be held responsible for wrongful deaths if they have acted in good faith, substandard medical practice is encouraged, physicians are protected from the con-sequences, and patients are left unprotected while believing they have acquired a new right.

The World Health Organization has recommended that governments not consider assisted suicide and euthanasia until they have demonstrated the availability and practice of palliative care for their citizens. All states and all countries have a long way to go to achieve this goal.

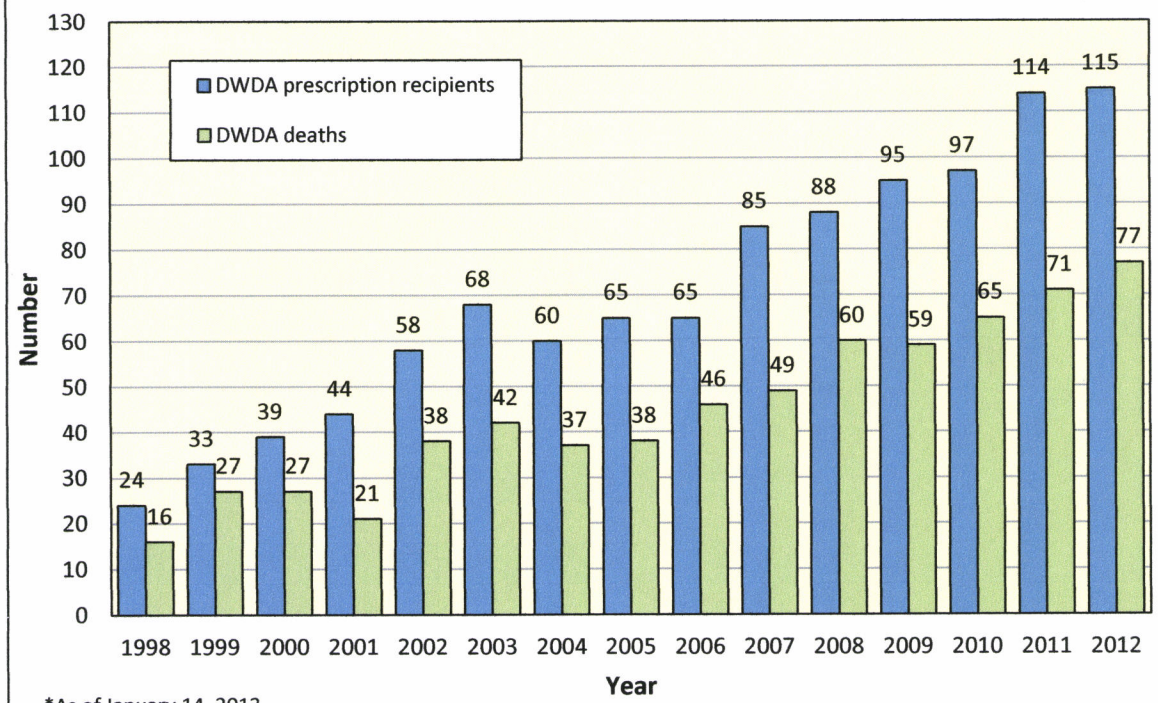
People are only beginning to learn that with well-trained doctors and nurses and good end-of-life care, it is possible to avoid the pain of the past experiences of many of their loved ones and to achieve a good death. The right to such care is the right that patients should demand and the challenge that every country needs to meet.

Oregon Public Health Division

Oregon's Death with Dignity Act--2012

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2012 are listed below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and deaths that occurred as a result of ingesting prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of January 14, 2013. For more detail, please view the figures and tables on our web site: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2012



*As of January 14, 2013

- As of January 14, 2013, prescriptions for lethal medications were written for 115 people during 2012 under the provisions of the DWDA, compared to 114 during 2011 (Figure 1). At the time of this report, there were 77 known DWDA deaths during 2012. This corresponds to 23.5 DWDA deaths per 10,000 total deaths.[1]

[1] Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2011 (32,731), the most recent year for which final death data is available.

Table 1. Characteristics and end-of-life care of 673 DWDA patients who have died from ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012

Characteristics	2012 (N=77)	1998-2011 (N=596)	Total (N=673)
Sex	N (%)[1]	N (%)[1]	N (%)[1]
Male (%)	39 (50.6)	308 (51.7)	347 (51.6)
Female (%)	38 (49.4)	288 (48.3)	326 (48.4)
Age			
18-34 (%)	0 (0.0)	6 (1.0)	6 (0.9)
35-44 (%)	1 (1.3)	14 (2.3)	15 (2.2)
45-54 (%)	8 (10.4)	44 (7.4)	52 (7.7)
55-64 (%)	16 (20.8)	123 (20.6)	139 (20.7)
65-74 (%)	23 (29.9)	170 (28.5)	193 (28.7)
75-84 (%)	18 (23.4)	168 (28.2)	186 (27.6)
85+ (%)	11 (14.3)	71 (11.9)	82 (12.2)
Median years (range)	69 (42-96)	71 (25-96)	71 (25-96)
Race			
White (%)	75 (97.4)	579 (97.6)	654 (97.6)
African American (%)	0 (0.0)	1 (0.2)	1 (0.1)
American Indian (%)	0 (0.0)	1 (0.2)	1 (0.1)
Asian (%)	1 (1.3)	7 (1.2)	8 (1.2)
Pacific Islander (%)	0 (0.0)	1 (0.2)	1 (0.1)
Other (%)	0 (0.0)	0 (0.0)	0 (0.0)
Two or more races (%)	0 (0.0)	0 (0.0)	0 (0.0)
Hispanic (%)	1 (1.3)	4 (0.7)	5 (0.7)
Unknown	*0*	*3*	*3*
Marital Status			
Married (%)[2]	33 (42.9)	271 (45.7)	304 (45.4)
Widowed (%)	23 (29.9)	134 (22.6)	157 (23.4)
Never married (%)	6 (7.8)	49 (8.3)	55 (8.2)
Divorced (%)	15 (19.5)	139 (23.4)	154 (23.0)
Unknown	*0*	*3*	*3*
Education			
Less than high school (%)	2 (2.6)	40 (6.8)	42 (6.3)
High school graduate (%)	13 (16.9)	139 (23.5)	152 (22.8)
Some college (%)	29 (37.7)	148 (25.0)	177 (26.5)
Baccalaureate or higher (%)	33 (42.9)	264 (44.7)	297 (44.5)
Unknown	*0*	*5*	*5*
Residence			
Metro counties (%)[3]	34 (44.2)	253 (42.7)	287 (42.8)
Coastal counties (%)	4 (5.2)	47 (7.9)	51 (7.6)
Other western counties (%)	37 (48.1)	250 (42.2)	287 (42.8)
East of the Cascades (%)	2 (2.6)	43 (7.3)	45 (6.7)
Unknown	*0*	*3*	*3*
End of life care			
Hospice			
Enrolled (%)[4]	64 (97.0)	522 (89.7)	586 (90.4)
Not enrolled (%)	2 (3.0)	60 (10.3)	62 (9.6)
Unknown	*11*	*14*	*25*
Insurance			
Private (%)[5]	36 (51.4)	382 (66.2)	418 (64.6)
Medicare, Medicaid or Other Governmental (%)	34 (48.6)	185 (32.1)	219 (33.8)
None (%)	0 (0.0)	10 (1.7)	10 (1.5)
Unknown	*7*	*19*	*26*

Characteristics	2012 (N=77)	1998-2011 (N=596)	Total (N=673)
Underlying illness			
Malignant neoplasms (%)	**58 (75.3)**	**480 (80.9)**	**538 (80.3)**
Lung and bronchus (%)	14 (18.2)	112 (18.9)	126 (18.8)
Breast (%)	4 (5.2)	52 (8.8)	56 (8.4)
Colon (%)	7 (9.1)	36 (6.1)	43 (6.4)
Pancreas (%)	2 (2.6)	42 (7.1)	44 (6.6)
Prostate (%)	5 (6.5)	26 (4.4)	31 (4.6)
Ovary (%)	2 (2.6)	25 (4.2)	27 (4.0)
Other (%)	24 (31.2)	187 (31.5)	211 (31.5)
Amyotrophic lateral sclerosis (%)	**5 (6.5)**	**44 (7.4)**	**49 (7.3)**
Chronic lower respiratory disease (%)	**2 (2.6)**	**25 (4.2)**	**27 (4.0)**
Heart Disease (%)	**2 (2.6)**	**10 (1.7)**	**12 (1.8)**
HIV/AIDS (%)	**1 (1.3)**	**8 (1.3)**	**9 (1.3)**
Other illnesses (%)[6]	**9 (11.7)**	**26 (4.4)**	**35 (5.2)**
Unknown	***0***	***3***	***3***
DWDA process			
Referred for psychiatric evaluation (%)	2 (2.6)	40 (6.7)	42 (6.2)
Patient informed family of decision (%)[7]	71 (92.2)	493 (94.4)	564 (94.2)
Patient died at			
Home (patient, family or friend) (%)	75 (97.4)	562 (94.8)	637 (95.1)
Long term care, assisted living or foster care facility (%)	2 (2.6)	25 (4.2)	27 (4.0)
Hospital (%)	0 (0.0)	1 (0.2)	1 (0.1)
Other (%)	0 (0.0)	5 (0.8)	5 (0.7)
Unknown	*0*	*3*	*3*
Lethal medication			
Secobarbital (%)	20 (26.0)	374 (62.8)	394 (58.5)
Pentobarbital (%)	57 (74.0)	215 (36.1)	272 (40.4)
Other (%)[8]	0 (0.0)	7 (1.2)	7 (1.0)
End of life concerns[9]	**(N=77)**	**(N=592)**	**(N=669)**
Losing autonomy (%)	72 (93.5)	538 (90.9)	610 (91.2)
Less able to engage in activities making life enjoyable (%)	71 (92.2)	523 (88.3)	594 (88.8)
Loss of dignity (%)[10]	60 (77.9)	386 (82.7)	446 (82.0)
Losing control of bodily functions (%)	27 (35.1)	318 (53.7)	345 (51.6)
Burden on family, friends/caregivers (%)	44 (57.1)	214 (36.1)	258 (38.6)
Inadequate pain control or concern about it (%)	23 (29.9)	134 (22.6)	157 (23.5)
Financial implications of treatment (%)	3 (3.9)	15 (2.5)	18 (2.7)
Health-care provider present[11]	**(N=77)**	**(N=526)**	**(N=603)**
When medication was ingested[12]			
Prescribing physician	8	100	108
Other provider, prescribing physician not present	4	231	235
No provider	1	72	73
Unknown	*64*	*123*	*187*
At time of death			
Prescribing physician (%)	7 (9.1)	89 (17.3)	96 (16.2)
Other provider, prescribing physician not present (%)	4 (5.2)	254 (49.4)	258 (43.7)
No provider (%)	66 (85.7)	171 (33.3)	237 (40.1)
Unknown	*0*	*12*	*12*
Complications[12]	**(N=77)**	**(N=596)**	**(N=673)**
Regurgitated	0	22	22
Seizures	0	0	0
None	11	463	474
Unknown	*66*	*111*	*177*
Other outcomes			
Regained consciousness after ingesting DWDA medications[13]	1	5	6

Characteristics	2012 (N=77)	1998-2011 (N=596)	Total (N=673)
Timing of DWDA event			
Duration (weeks) of patient-physician relationship[14]			
Median	19	12	12
Range	0-1640	0-1905	0-1905
Number of patients with information available	*77*	*594*	*671*
Number of patients with information unknown	*0*	*2*	*2*
Duration (days) between 1st request and death			
Median	47	46	46
Range	16-388	15-1009	15-1009
Number of patients with information available	*77*	*596*	*673*
Number of patients with information unknown	*0*	*0*	*0*
Minutes between ingestion and unconsciousness[11]			
Median	5	5	5
Range	3-15	1-38	1-38
Number of patients with information available	*11*	*462*	*473*
Number of patients with information unknown	*66*	*134*	*200*
Minutes between ingestion and death[11]			
Median	20	25	25
Range (minutes - hours)	10min-3.5hrs	1min-104hrs	1min-104hrs
Number of patients with information available	*11*	*467*	*478*
Number of patients with information unknown	*66*	*129*	*195*

1 Unknowns are excluded when calculating percentages.

2 Includes Oregon Registered Domestic Partnerships.

3 Clackamas, Multnomah, and Washington counties.

4 Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.

5 Private insurance category includes those with private insurance alone or in combination with other insurance.

6 Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.

7 First recorded beginning in 2001. Since then, 24 patients (4.0%) have chosen not to inform their families, and 11 patients (1.8%) have had no family to inform. There was one unknown case in 2002, two in 2005, and one in 2009.

8 Other includes combinations of secobarbital, pentobarbital, and/or morphine.

9 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

10 First asked in 2003. Data available for all 77 patients in 2012, 467 patients between 1998-2011, and 544 patients for all years.

11 The data shown are for 2001-2012 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.

12 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

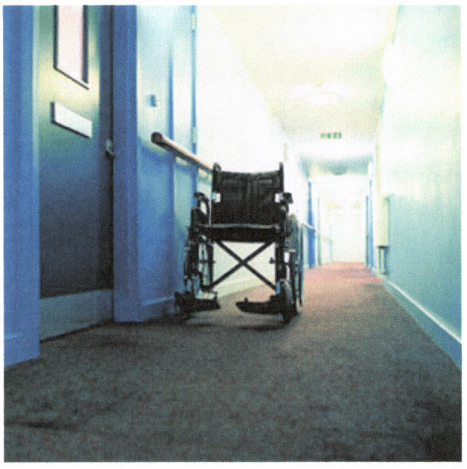
13 There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (http://www.healthoregon.org/dwd) for more detail on these deaths.

14 Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.

3/20/2013 5:15 PM ET | By Anthony Mirhaydari, MSN Money

Why we need 'death panels'

We're taxing young people and running up debt to fund an overpriced system and offer end-of-life 'care' that may not do much good. It's time to put scary monikers aside.



Miyamoto Musashi was a serious man.

The warrior-poet walked the medieval Japanese countryside seeking duels with the strongest warriors he could find. He lived a pure ascetic existence. He didn't care where he slept. He carried no money or food. And when too old to fight, after a life on the edge of mortality, he wrote philosophy in a cave.

So, pretty much the exact opposite of the modern American lifestyle.

Yet as our country grapples with a dangerous debt/deficit problem, caused by demographic challenges and an overpriced and inefficient health care system, we should pay heed to two of Musashi's most important precepts. The first is to do nothing that is of no use. The second is to accept death in the midst of life.

In other words, Musashi would probably support "death panels" -- the concept of end-of-life counseling -- to guide treatment for the terminally ill. So do I. Here's why.

The twilight of life

First, we need to remember where the term "death panel" came from. The idea had fairly broad support until funding for it was included in Obamacare. Opponents framed it as government bureaucrats pulling the plug on grandma (when it was really about doctors being realistic with patients), and amid a backlash, it was pulled.

That was stupid. These questions demand far more serious discussion.

The fact is, 25% of all Medicare spending goes to the 5% of recipients who die each year --with 80% of that in the last two months of life. This is aggressive spending on things like stays in intensive care and critical care units, which research has shown do not meet the needs and preferences of terminal patients despite its increasing use.

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MARKET UPDATE

Especially when combined with the growing evidence supporting the benefits of less-expensive, palliative hospice care that allows people to enjoy their last days on this earth in peace at home, not poked, prodded and intubated, floating in and out of consciousness under the fluorescent lights of a $30,000-a-night hospital room.

Anthony Mirhaydari

The popular backlash against death panels gave politicians in Washington reason to fear the topic in general.

But by avoiding the issue, we're choosing to increase the burden on future generations by piling on debt, raising taxes, weakening our defenses, neglecting needed investments and generally damaging the future vitality of the country. This is nothing less than a slow-burn moral disgrace and a reversal of the archetype of parental self-sacrifice and responsibility.

We can't have it all anymore. Think about that before you feign outrage.

If we're going to truly address the long-term budget problems that threaten the welfare of our children and our children's children, we need to address Medicare and, in particular, end-of-life care -- a topic that's been off limits since Sarah Palin unleashed the debate four years ago.

We need leaner health care

Really, this discussion could be much broader.

One reason the economy's natural growth rate has slowed -- and resulted in a pitiful recovery from the 2008 recession -- is because government-led areas have become inefficient and overpriced -- and are underperforming relative to those of our global peers. Like a cancer, it's sucking precious resources from other, more productive areas of the economy.

I'm talking education, where we spend nearly 50% more per pupil than the average developed economy but rank in the bottom third in global math and science achievement rankings behind countries like China, Singapore, South Korea and Finland. I'm talking about wasteful spending, which according to a Gallup poll, has Americans believing that Washington wastes 50 cents of every dollar it spends -- up from 38 cents in 1988. And I'm talking health care, where we spend far more per person than other rich-world countries, yet have mediocre quality-of-health measures, from infant mortality and hospital-borne infections to the fact that one-third of U.S. adults are obese.

These are areas that haven't been subjected to the profit-seeking, headcount-reducing, output-maximizing forces of globalization and technological change as broad swaths of the manufacturing, business services and retailing sectors have been.

But let's focus on health care, since it's the hinge on which the current budget fight turns. In 2009, Americans spent $7,960 per person on health care versus $4,808 in Canada, $4,218 in Germany and $3,978 in France. If we could reduce per person health costs, the budget deficit would melt away.

Truth is, our health care system lacks the discipline of a true single-payer, government-run system or the power of truly competitive, free-market forces.

This has allowed profits in the pharmaceutical and medical supply industry to soar, health care costs to consistently outpace the overall rate of inflation and truly haywire pricing. There's no reason an MRI should cost $1,080 in America but just $280 in France, according to the International Federation of Health Plans. Or why the cost of an MRI in Washington D.C. varies, depending on provider, from $400 to $1,861.

We can't afford inaction

Yet instead of meaningful reforms, we're merely chipping away at the edges while pouring even more taxpayer cash into a broken system. Obamacare's focus is largely on expanding coverage to uninsured Americans, either by fiat (individual mandate) or by greatly expanding government assistance via Medicaid. This strategy isn't sufficient; it doesn't cut costs.

And we can no longer afford to fund this failure, with the national debt set to soar from $16.7 trillion now (or $53,000 for every man, woman and child) to $25 trillion by 2023, a 49% increase.

With our debt-to-GDP ratio already over 100% and rising, we're in the red zone of excess indebtedness. Economists warn that if we don't turn things around, we'll damage the economy's ability to grow; reduce our ability to respond to wars, natural disasters and recessions; and increase our vulnerability to financial panics. And we'll also increasingly be on the hook for interest payments,

paying our bondholders in China and Japan instead of paving new roads or building new schools.

The problem is health care spending, not low taxes. In 2023, the Congressional Budget Office expects tax revenue to be nearly double 2012's total. Yet it projects the deficit at nearly $1 trillion. That's because spending will rise too fast, with average annual gains of 6.2% for Medicare and nearly 10% for Medicaid.

The truth is that as health care costs rise in this broken system, entitlement programs can't keep up. We're overpromising benefits to seniors: The average two-earner couple that retired in 2010 will enjoy $387,000 in Medicare benefits after contributing (assuming a 2% real rate of return) $122,000 in Medicare taxes.

Generational warfare

In essence, out of fear of angering important voting blocs -- not just those on Medicare now, but a generation of baby boomers now reaching the age of eligibility -- we're asking future generations to foot the bill. If we simply cashed out the system, giving seniors back the Medicare taxes they paid in instead of charging it to the national credit card, the result would look a lot like Republican House Budget Committee Chairman Paul Ryan's "premium-support" plan.

If people wanted more health care, they'd have to pay for it out of pocket. If they had unhealthy lifestyles, they'd pay more out of pocket. And it would encourage holistic care options, not just fee-for-service Medicare that encourages doctors and hospitals to order more tests and more procedures to maximize revenue.

While I find the Ryan idea attractive, since it solves the budget problem and unleashes free-market forces on the health care system, voters rejected it last November.

And yes, this may sound like I want to leave some seniors out in the cold. But is what we're doing to young people any more fair?

This premium-support idea is already happening to young working adults, many with new families. Employers are increasingly offering health insurance subsidies instead of paying for coverage outright. Unable to pay much out of pocket, because of stagnant wages and higher living expenses, these young folks are forced into high-deductible, low-coverage health insurance plans.

All the while, their payroll taxes go to support Medicare seniors receiving more than they paid in.

It's no wonder these people -- the backbone of the economy -- are so stressed as the evidence builds the American dream is slipping away from them. (Read about the economic stress on young workers in this study by the American Psychological Association, and their inability to build wealth in this one from the Urban Institute.)

This brings me back to Musashi.

If we're going to end this slide into the fiscal abyss and stop the intergenerational heist, we need to address both the cost of care and the fact that so much goes to giving a few more days of low-quality life to the terminally ill. These resources could be better spent preparing the way for those just starting in life, while still providing our seniors with a more dignified end.

Bipartisan support does seem to be coalescing around means-testing for Medicare benefits, so that those who can afford it pay more. That's great, but we also we need to encourage increased use of hospice care while discouraging repeated and outrageously expensive hospitalizations.

Think that's inhumane? This heartbreaking New Yorker story by surgeon Atul Gawande about the current state of end-of-life care will change your mind.

And consider what you'd do if you had to pay those expenses out of pocket, as so many young families have to. Death is inevitable. Would you impoverish your family in an ultimately unsuccessful fight against it?

We need to celebrate our mortality, appreciate how delicate the balance between life and death is, and understand that a better life and a longer life aren't necessarily the same thing -- especially if it consumes resources desperately needed by the generations to come.

Musashi understood this. It's time we did, too.

Be sure to check out Anthony's new money management service, Mirhaydari Capital Management, and his investment newsletter, the Edge. A free, two-week trial subscription to the newsletter has been extended to MSN Money readers. Click here to sign up. Mirhaydari can be contacted at anthony@edgeletter.com and followed on Twitter at @EdgeLetter. You can view his current stock picks here. Feel free to comment below.

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Attempts to Legalize Euthanasia/Assisted-Suicide in the United States

In the United States, Oregon was the first state to legalized physician-assisted suicide. At that time, assisted-suicide advocates predicted that there would be a rapid "domino effect," and other states would soon follow Oregon's lead. But they were wrong. It took fourteen years before another state legalized the practice, and, even then, only after advocates spent a whole year preparing the campaign and raising millions of dollars to insure the victory they so desperately wanted. That state was Washington, the state consultants said was demographically most like Oregon and, therefore, most likely to favor assisted suicide.

But, since Oregon legalized assisted suicide in 1994, other states have rejected assisted-suicide measures, many multiple times. **From January 1994 to December 2012, there were 126 legislative proposals in 25 states.** All bills that are not currently pending were either defeated, tabled for the session, withdrawn by sponsors, or languished with no action taken.

Here is a listing, by state, of all the ballot initiatives (since 1991) and all the legislative measures (since 1994) to legalize euthanasia and/or doctor-prescribed suicide in the U.S.

Ballot Initiatives that Passed

Oregon – 1994

Ballot Measure 16 (Oregon Death with Dignity Act) passed on November 8, 1994, by the narrow margin of 51% to 49%. By legalizing physician-assisted suicide, the ballot measure transformed the crime of assisted suicide into a medical treatment.

Washington State — 2008

Ballot Initiative 1000 (Washington Death with Dignity Act) passed on November 4, 2008, by a vote of 58% to 42%. The Washington law is virtually identical to Oregon's assisted-suicide law.

Ballot Initiatives that Were Defeated

Washington State – 1991

Ballot Initiative 119, which would have legalized "aid-in-dying" (both doctor-administered euthanasia and doctor-prescribed suicide), was defeated by a vote of 54% to 46%.

California – 1992

Proposition 161, a ballot initiative that would have legalized euthanasia and physician-assisted suicide failed by a vote of 54% to 46%.

Michigan – 1998

Measure B, which would have legalized physician-assisted suicide, was overwhelmingly rejected by a margin of 71% to 29%.

Maine – 2000

Question 1, the "Maine Death with Dignity Act," patterned after the "Oregon Death with Dignity Act" would have legalized physician-assisted suicide. It was defeated by voters 51% to 49%.

Massachusetts – 2012

Question 2, the "Massachusetts Death with Dignity Act," patterned after the "Oregon Death with Dignity Act" would have legalized doctor-prescribed suicide. It was defeated by voters 51% to 49%.

Legislative Measures – January 1994 to December 2012

(Introduced, but not passed)

Alaska
HB 371 (1996)

Arizona
SB 1007 (1996)
HB 2167 (1999)
HB 2454 (2003)
HB 2564 (2004)
HB 2311, HB 2313 (2005)
HB 2372, HB 2357 (2007)
HB 2387 (2008)

California
AB 1080, AB 1310 (1995)
AB 1592 (1999)
AB 654 (2005)
AB 651 (2006)
AB 374 (2007)

Colorado
HB 95-1308 (1995)
HB 96-1185 (1996)

Michigan
HB 4134 (1994)
SB 640 (1995)
SB 653 (1997)
HB 5474 (1998)

Mississippi
HB 1023 (1996)

Montana
SB 220 (2013)
SB 167 (2011)

Nebraska
LB 1259 (1996)
LB 406 (1997)
LB 70 (1999)

New Hampshire
HB 339 (1996)
HB 1433-FN (1998)
SB 44 (1999)
HB 304 (2009)

Connecticut
HB 6928, SB 334 (1995)
HB 6083 (1997)
SB 1138 (2009)
HB 6645 (2013) pending

Hawaii
SB 2095 (1998)
HB 418, HB 347, SB 981, SB 692, HB 1155, SB 1037 (1999)
HB 2491, SB2749, SB 709 (2001)
HB 2487, SB 2745 (2002)
HB 862, SB 391 (2003-2004)
HB 1454, SB 1308 (2005)
HB 3013, SB 2900 (2006)
HB 675, SB 800, SB 1995 (2007)
HB 587, HB 806, SB 1159 (2009)
HB 803, HB 1383, HB 1165 (2011)
HB 606 (2013) pending

Illinois
HB 601, SB 948 (1997)

Iowa
HB 2425 (2006)

Kansas
HB 2068 (2013) pending
HB 2108 (2013) pending

Louisiana
SB 128 (1999)

Maine
HB 552 (1995)
LD 916 (1996)
HB 663 (1997)
IB 3, IB 10 (1999)

Maryland
HB 933, HB 474 (1995)

Massachusetts
H 3173 (1995)
HB 513 (2011)

New Jersey
A 3328, S 2259 (2012) pending

New Mexico
SB 446 (1995)
HB 814 (2009)

New York
S 1683, S 5024-A, A 6333 (1995)
SB 4834 (1999)
SB 677 (2001)
AB 9360 (2012) (withdrawn 5/9/12)

Pennsylvania
HB 1435 (2007)
SB 404 (2009)
SB 431 (2011)

Rhode Island
SB 2985 (1995)
SB 2869 (1998)
SB 2763 (2001)
HB 7428, SB 2766 (2006)
HB 6080 (2007)

Vermont
H 335 (1995)
H 109 (1997)
H 493 (1999)
H 318, S 112 (2003-2004)
H 168 (2005-2006)
H 44, S 63 (2007)
H 455, S 144 (2009)
H 274, S.103 (2011-2012)
S 77 (2013) pending

Washington
SB 5596 (1995)
SB 6576 (1998)
SB 6843 (2006)

H 1543 (1997)
H 1468 (2009)
H 2233 (2011)
H 3884 (2012)

Wisconsin

AB 174, SB 90 (1995)
AB 32, SB 27 (1997)
AB 297, SB 124 (1999)
AB 417, SB 184 (2001)
AB 348, SB 169 (2003)
AB 507, SB 224 (2005)
AB 298, SB 151 (2007)

Wyoming

SB 7 (2004)

For more extensive information about U.S. proposals to legalize euthanasia and assisted suicide, see:

"Euthanasia, Assisted Suicide & Health Care Decisions" (2006)
"Assisted Suicide & Death with Dignity: Past, Present & Future" (2004)
"Assisted Suicide: The Continuing Debate" (2002)
"The Art of Verbal Engineering" (1996)
Update: on-line editions (1996 – Present)

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